

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			c. LENGTH OF STAY IN 1b <u>19</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General</u>					d. STREET ADDRESS <u>61 Clay Street</u>						
3. NAME OF DECEASED (Type or print) First <u>Sedonia</u> Middle Last <u>Abrams</u>					4. DATE OF DEATH Month <u>9</u> Day <u>10</u> Year <u>19 60</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-12-1891</u>		9. AGE (In years last birthday) <u>69</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Unknown</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or if unknown) <u>No</u> (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT <u>Anna Turner 45 North Ave.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Cardiac Failure</u> <u>434 J</u> DUE TO (b) <u>about 3 hrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> , to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>A. T. Allen</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>A. T. ALLEN</u>					22d. ADDRESS <u>61 Clay Street</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>9-14-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>National</u>		23d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>					ADDRESS <u>Anna. Md</u>		25a. REC'D BY REGISTRAR <u>SEP 19 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>		

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

9901 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b ?		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 60 Glen Burnie		d. STREET ADDRESS Neck Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) New Bohemian Beach, Off Marley Neck Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LEO		First T. Middle		Last AMBROSE		4. DATE OF DEATH Month September Day 26 Year 19 60	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 17, 1899	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 60 Days		IF UNDER 24 HRS. Hours 60 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Southern Hotel		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Frank M. Cookerly		Address 2026 Russell Ave. 7	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Destruction of Body by Burning. 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Conflagration of home					
20c. TIME OF INJURY Hour 9:15 p.m. Month, Day, Year 9/26 1960		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Glen Burnie Anne Arundel Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Petty		M.D. Charles S. Petty, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/27/60	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county) Baltimore Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 29, 60		22c. NAME OF CEMETERY OR CREMATORY Western Cemetery		22d. LOCATION (City, town, or country) (State) Baltimore Md.	
23. FUNERAL DIRECTOR John . T. Stansbury				ADDRESS 6411 Windsor Mill Rd.		24a. REC'D BY REGISTRAR SEP 29 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Frank			

MEDICAL CERTIFICATION

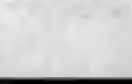
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 9 Film G271 9-28-60 et

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Shore Acres</i> <i>A.A. County - Arnold</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Arnold</i> c. LENGTH OF STAY IN 16 <i>Arnold</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Shore Acres</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>A.A. CO.</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Arnold</i> d. STREET ADDRESS <i>15 E. Lake Dr. Shore Acres</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Harry Ellsworth AULT, Jr.</i>		4. DATE OF DEATH Month <i>9</i> Day <i>8</i> Year <i>1960</i>	
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>June 20, 1901</i> <i>Sept. 16, 1901</i>	
9. AGE (In years last birthday) <i>58</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Blacksmith</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>B. & O. R. R.</i>	
11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>late Harry E. Ault</i>		14. MOTHER'S MAIDEN NAME <i>Minnie ----Ault</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Miss Minnie Ault, 333 S. Gilmore St</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Mitral insufficiency & cardiac failure</i> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i> <i>3 wks</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>chronic rheumatoid arthritis for 10 years</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8-25, 1960</i> to <i>9-8, 1960</i> , that I last saw the deceased alive on <i>9-6, 1960</i> , and that death occurred at <i>MAH</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>Bertrand C. R. Gall</i> M.D. <i>Cape St. Claire Rt 4</i> <i>9-8-60</i> PHYSICIAN'S NAME (Type) <i>Bertrand C. R. Gall</i> <i>Annapolis Md</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9/12/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Witzke Funeral Directors, 4101 E. Edmondson Ave</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 13 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

CERTIFICATE OF DEATH

1900

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of death: [illegible]
5. Place of death: [illegible]
6. Cause of death: [illegible]
7. Signature of physician: [illegible]
8. Signature of registrar: [illegible]
9. Date of registration: [illegible]

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9860

09832

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anna Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle M. C. Last BEALL		4. DATE OF DEATH Month September Day 18 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 6, 1889
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 70	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (own farm)		10b. KIND OF BUSINESS OR INDUSTRY Tobacco	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Beall		14. MOTHER'S MAIDEN NAME Rosa Talbott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213 22 1181	
17. INFORMANT Mrs. Barbara Messenger; Daughter; Same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. Acute pulmonary edema (b) 420.1 (c) Due to		INTERVAL BETWEEN ONSET AND DEATH 1 wk 1 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Emphysema		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) the deceased attended the deceased from Sept. 13, 1960 to Sept. 18, 1960 that (I) was last saw the deceased alive on Sept. 18, 1960 and that death occurred at 2:05 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Frank M. Shipley		22b. DATE SIGNED 9/19/60	
22c. PHYSICIAN'S NAME (Type) Frank M. Shipley		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 20, 1960	
23c. NAME OF CEMETERY OR CREMATORY All Hallows		23d. LOCATION (City, town, or county) (State) Davidsonville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		25a. REC'D BY REGISTRAR SEP 20 '60	
ADDRESS Annapolis, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
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VR A15 (4)
ISM 9/59

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09833

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 304 State St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ernest Middle L. Last BELL Sr.				4. DATE OF DEATH Month September Day 24 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 29, 1907	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months 53 Days 53 Hours 53 Min.		IF UNDER 24 HRS. Months 53 Days 53 Hours 53 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Agent				10b. KIND OF BUSINESS OR INDUSTRY Life Insurance		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Ernest H. Bell				14. MOTHER'S MAIDEN NAME Nettie M. Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. —		17. INFORMANT Katherine F. Bell Address # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) 8 hrs. INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) physician attended the deceased from Sept. 24, 1960 , to Sept. 24, 1960 , that (I) yes last saw the deceased alive on Sept. 24, 1960 , and that death occurred at 5:10 P.M. M, from the causes and on the date stated above.							
22a. SIGNATURE John L. Hedeman				22b. DATE SIGNED 9/26/60		22c. PHYSICIAN'S NAME (Type) John L. Hedeman	
22d. ADDRESS 121 Cathedral St., Annapolis, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9-27-1960		23c. NAME OF CEMETERY OR CREMATORY Hillcrest		23d. LOCATION (City, town, or county) (State) Annapolis Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Sons ADDRESS Annapolis, Md.				25a. REC'D BY REGISTRAR SEP 28 '60		25b. REGISTRAR'S SIGNATURE Charles S. Kraus	

Date: _____

Name: _____

Room: _____

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Subject: _____

Date: _____

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CERTIFICATE OF DEATH

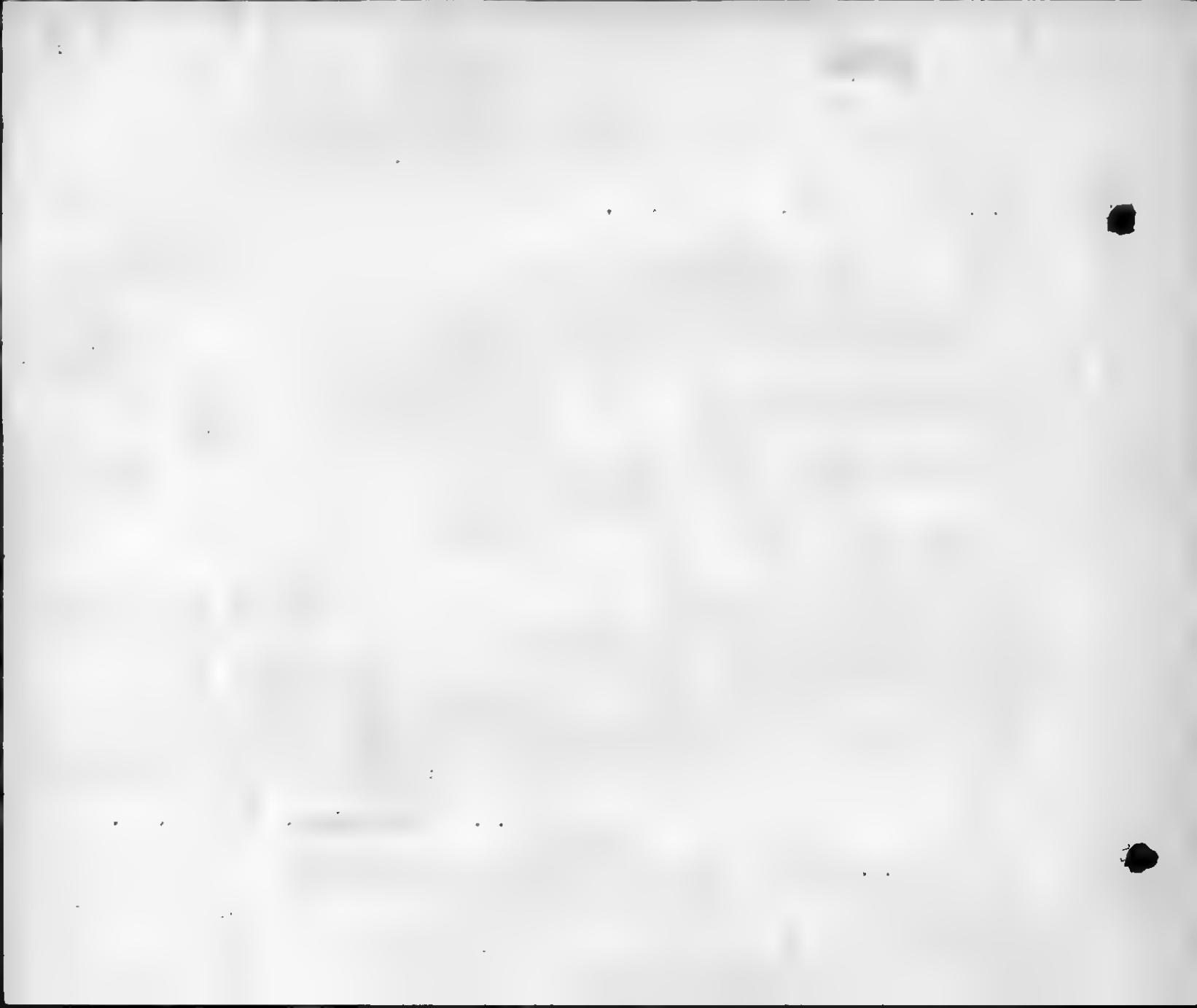
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Annapolis, Md.		d. STREET ADDRESS 102 Cathedral Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Ida Messick BELL		4. DATE OF DEATH Month Day Year September 18 19 60	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 29 FEB 1892
9. AGE (In years last birthday) yrs. 68		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles HYDE		14. MOTHER'S MAIDEN NAME Ida MESSICK JONES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO —	
17. INFORMANT William H Bell		Address (2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 430.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (1) Diabetis Mellitus (2) Peptic ulcer 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 16 September, 19 60 , to 18 September, 19 60 , that I last saw the deceased alive on 18 September, 19 60 , and that death occurred at 10:07 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Edward C. Keene M.D.		U.S. Naval Hospital, Annapolis, Md.	
PHYSICIAN'S NAME (Type) E.C. KEENE LT MC USNR		18 September 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept 21-60	22c. NAME OF CEMETERY OR CREMATORY National Cemetery	22d. LOCATION (City, town, or county) (State) Annapolis Md.
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sr.		24a. REC'D BY REGISTRAR SEP 21 '60	
ADDRESS Annapolis Md.		24b. REGISTRAR'S SIGNATURE William S. Kline	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

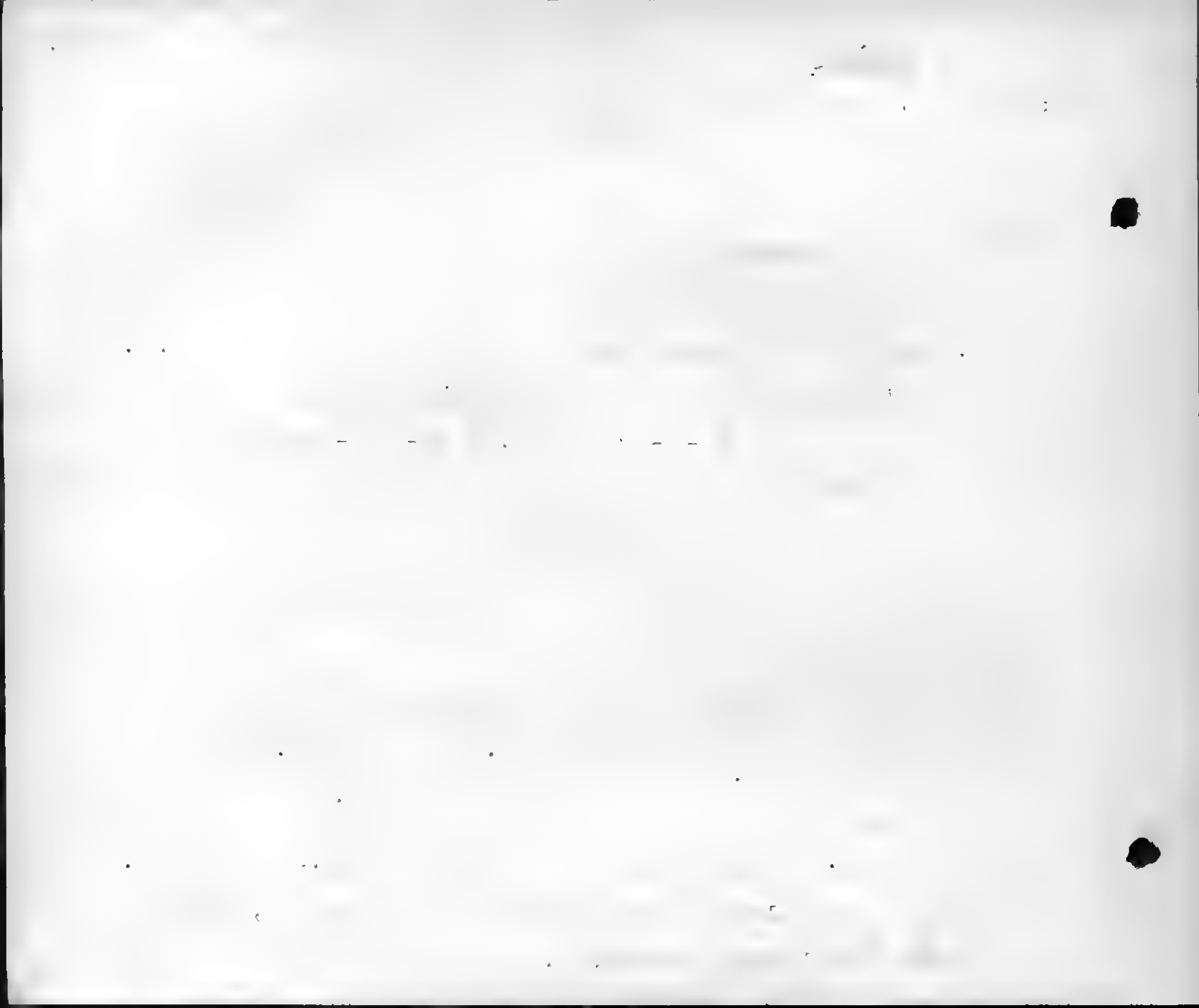
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9863

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09835

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 114 Prince George Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First BARNEY Middle Berman Last Berman				4. DATE OF DEATH Month September Day 21 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 15, 1892	
9. AGE (In years last birthday) 68 yrs		10. IF UNDER 1 YEAR Months 68 Days 68 Hours 68 Min 68		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Prop.				10b. KIND OF BUSINESS OR INDUSTRY Clothing store		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME Samuel Berman				14. MOTHER'S MAIDEN NAME Fannie (Unk)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-32-9111		17. INFORMANT Anna D. Berman- Wife- same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) A cute septicemia 053.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH 24 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) A cute pyelonephritis, renal failure, hypertension							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the physician) attended the deceased from Sept. 2, 1960 to Sept. 21, 1960 , that (I) (we) last saw the deceased alive on Sept. 21, 1960 , and that death occurred at 6:50 P.M. M, from the causes and on the date stated above.							
22a. SIGNATURE Gerald Church				22b. DATE SIGNED 9/23/60		22c. PHYSICIAN'S NAME (Type) Dr. Gerald Church	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 25, 1960		23c. NAME OF CEMETERY OR CREMATORY Kneseth Israel Cemetery		23d. LOCATION (City town or county) (State) Annapolis, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				25a. REC'D BY REGISTRAR SEP 26 '60		25b. REGISTRAR'S SIGNATURE Charles P. Harris	



may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

9903

CERTIFICATE OF DEATH

Reg. Dist. No.

09836

1. PLACE OF DEATH a. COUNTY <u>Ann Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Ann Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>				c. LENGTH OF STAY IN 1b <u>3 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beltsville Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>			
f. STREET ADDRESS <u>Beltsville (Lake Shore)</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>August Frederick Babbitt</u>				4. DATE OF DEATH <u>Sept 6 1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 25, 1922</u>	
9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Police Officer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>August Babbitt Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Emma Swanson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>7995 45</u>			
17. INFORMANT <u>Gertrude Babbitt</u>				Address <u>None</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral embolism</u>							
DUE TO <u>Cerebral embolism</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Myocardial Damage</u>							
DUE TO <u>Myocardial Damage</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year <u>Sept 5 1960</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>5/12 1937</u> to <u>9/5 1960</u> that I last saw the deceased alive on <u>5/12 1960</u> , and that death occurred at <u>7:25 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. M. P. C. HANSEN</u>				DATE SIGNED <u>9/6/60</u>			
PHYSICIAN'S NAME (Type) <u>R. M. P. C. HANSEN</u>				ADDRESS <u>Beltsville</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>9 Sept 1960</u>		<u>Beltsville</u>		<u>Beltsville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. P. HANSEN</u>				24a. REC'D BY REGISTRAR <u>SEP 13 60</u>			
24b. REGISTRAR'S SIGNATURE <u>C. S. HANSEN</u>							

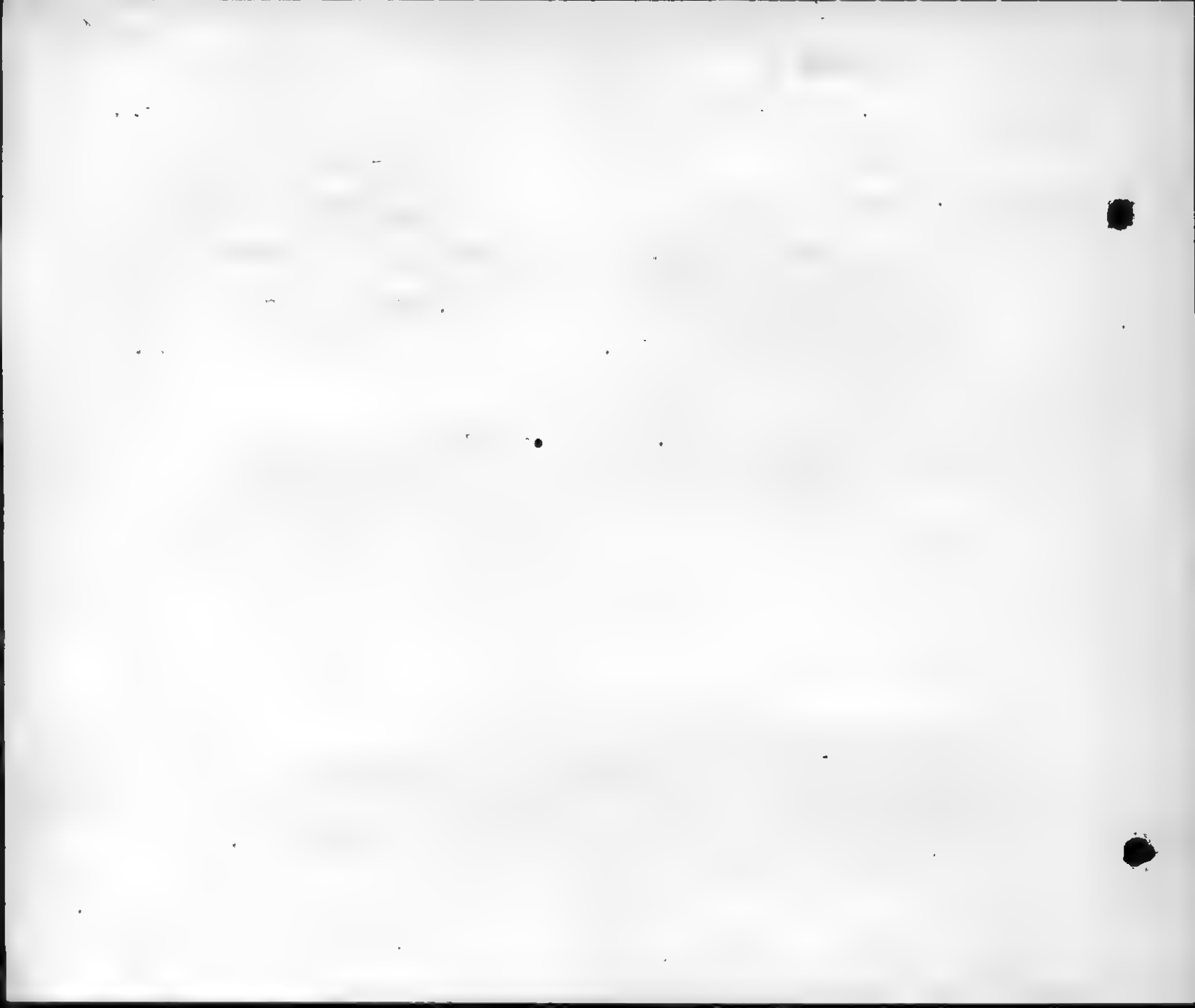


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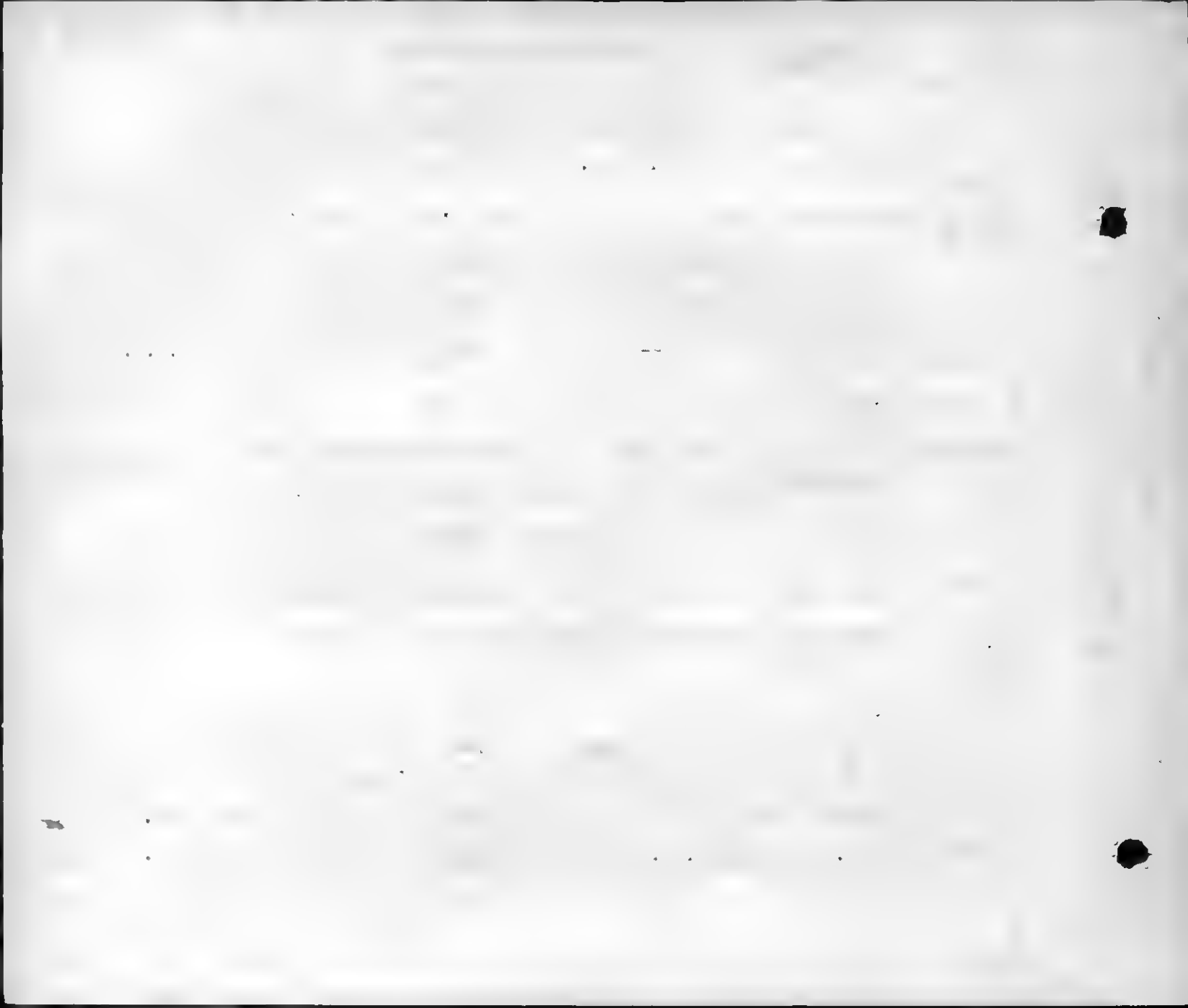
1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 4 1/2 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Annapolis		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS Deep Creek		4. DATE DEATH September 3 1960		9. AGE (In years last birthday) 37 yrs	
3. NAME OF DECEASED (Type or print) Robert G. BRAGG		First Middle Last		4. DATE DEATH September 3 1960		9. AGE (In years last birthday) 37 yrs	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 30, 1923	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Home Bldg.		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Ira Bragg		14. MOTHER'S MAIDEN NAME Mary Cox		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 230 25 4286	
17. INFORMANT Hospital Records		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ruptured Basilar aneurysm. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (physician) attended the deceased from 9-3-60 to 9-3-60 , that (I) (physician) saw the deceased alive on 9-3-60 , and that death occurred at 221 , from the causes and on the date stated above.		22a. SIGNATURE Frank M. Shipley		22b. DATE 9/5/60		22c. PHYSICIAN'S NAME (Type) Frank M Shipley	
22d. ADDRESS 221 Cathedral St. Annapolis, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 8, 1960		23c. NAME OF CEMETERY OR CREMATORY Arlington National	
23d. LOCATION (City, town, or county) (State) Arlington, Virginia		24. FUNERAL DIRECTOR'S SIGNATURE Herring and Kirkley		24b. ADDRESS Glen Burnie, Maryland		25a. REC'D BY REGISTRAR DATE SEP 7 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. REGISTRAR'S NAME Arthur S. Kraus		25d. REGISTRAR'S ADDRESS 1000 ...		25e. REGISTRAR'S CITY, TOWN, OR COUNTY Annapolis, Md.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18																			
9904 CERTIFICATE OF DEATH																			
Reg. Dist. No. 09838																			
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>					c. LENGTH OF STAY IN TB <u>3mos. 14das.</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>					d. STREET ADDRESS <u>808 N. Wolfe Street</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>Albert Oscar Lee Branch</u>					4. DATE OF DEATH Month Day Year <u>9 16 1960</u>														
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1894</u>		9. AGE (in years lost birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>*****</u>					11. BIRTHPLACE (State or foreign country) <u>Virginia</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Albert Branch</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>					16. SOCIAL SECURITY NO <u>Unknown</u>					17. INFORMANT <u>Hospital Records</u>					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia and Cardiac Failure</u> 903.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Open Reduction of Hip Fracture</u> DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome associated with Arteriosclerosis</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <u>Slept or fell in bathroom</u>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)														
20c. TIME OF INJURY Month Day Year <u>8 20 1960</u> Hour <u>2</u> p. m.					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work of work					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>					20f. (City or town) <u>Crownsville</u> (County) <u>AA</u> (State) <u>Md</u>				
21. I certify that I attended the deceased from <u>6/2/1960</u> to <u>9/16/1960</u> , that I last saw the deceased alive on <u>9/16/1960</u> , and that death occurred at <u>2:40A.M.</u> from the causes and on the date stated above.										ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md.</u>					DATE SIGNED <u>9/16/60</u>				
ACTUAL SIGNATURE <u>[Signature]</u>					M.D. <u>Crownsville State Hospital, Md.</u>					DATE SIGNED <u>9/16/60</u>									
PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u>					Crownsville State Hospital, Md.					DATE SIGNED <u>9/16/60</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>9-20-60</u>					22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u>					22d. LOCATION (City, town, or county) (State) <u>Anne Arundel Co. Md.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>					ADDRESS <u>1412 E. Preston St.</u>					24a. REC'D BY REGISTRAR <u>[Signature]</u>					24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				
					DATE <u>SEP 20 '60</u>														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

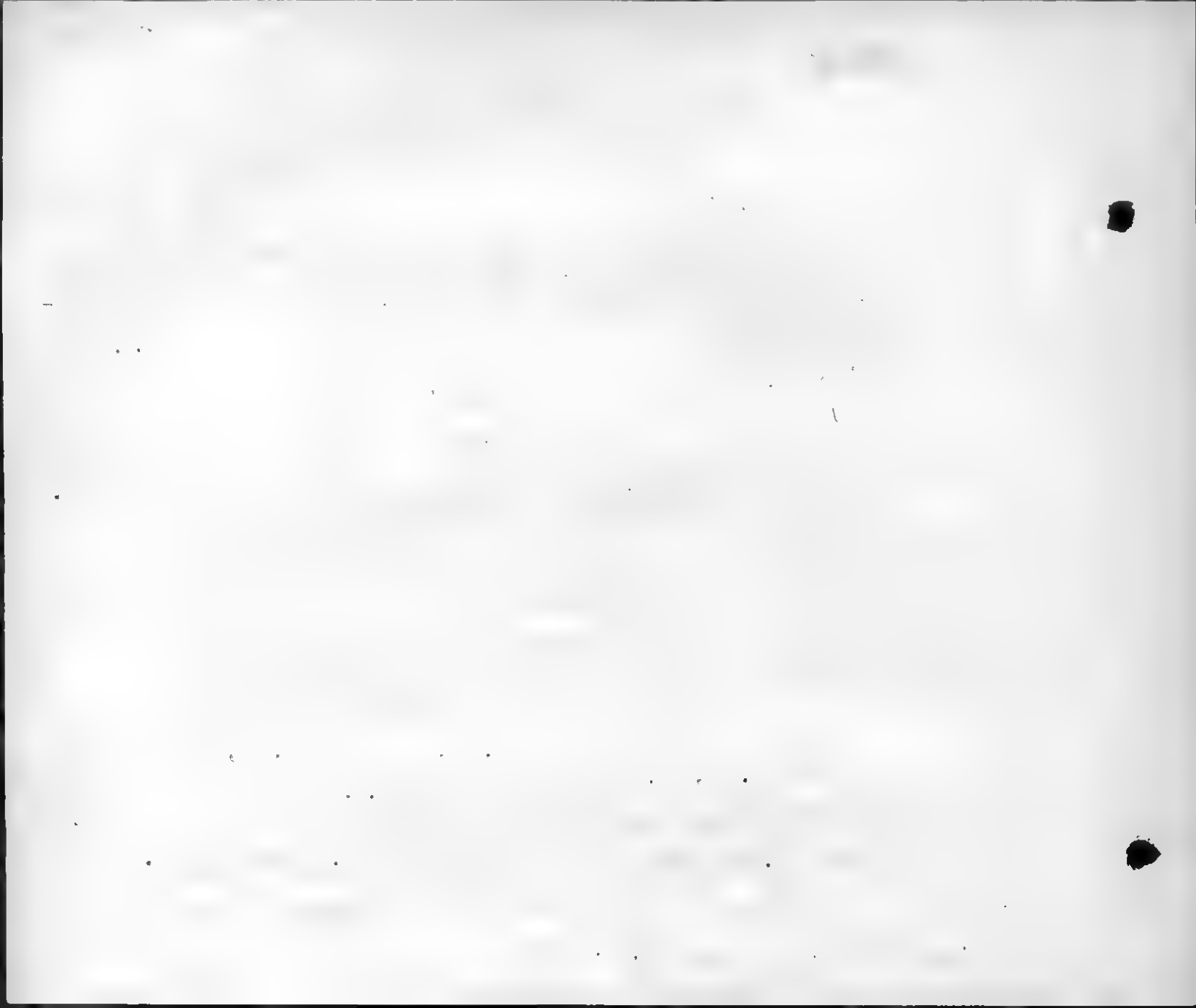
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15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9865

09839

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 1 day	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL * Odenton		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Fred Middle Allen Last BREWER		4. DATE OF DEATH Month September Day 11 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 10, 1960
9. AGE (In years last birthday) yrs. 18 Min --		10. IF UNDER 1 YEAR Months 18 Days -- Hours -- Min --	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Jack Palmer		14. MOTHER'S MAIDEN NAME Janet Louise Brewer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Mother	
17. INFORMANT Mother		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity and immaturity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 18 hrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a m 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the physician) attended the deceased from Sept. 10, 1960 to Sept. 11, 1960 , that (I) (we) last saw the deceased alive on Sept. 11, 1960 , and that death occurred at 10:10 A.M. from the causes and on the date stated above			
22a. SIGNATURE W. P. Stephens		22b. DATE SIGNED 9/12/60	
22c. PHYSICIAN'S NAME (Type) William P. Stephens		22d. ADDRESS 38 Cornhill St., Annapolis, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 12, 1960	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		23d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		ADDRESS Annapolis, Maryland	
25a. REC'D BY REGISTRAR SEP 13 '60		25b. REGISTRAR'S SIGNATURE Catherine S. Kline	



9866

CERTIFICATE OF DEATH

09840

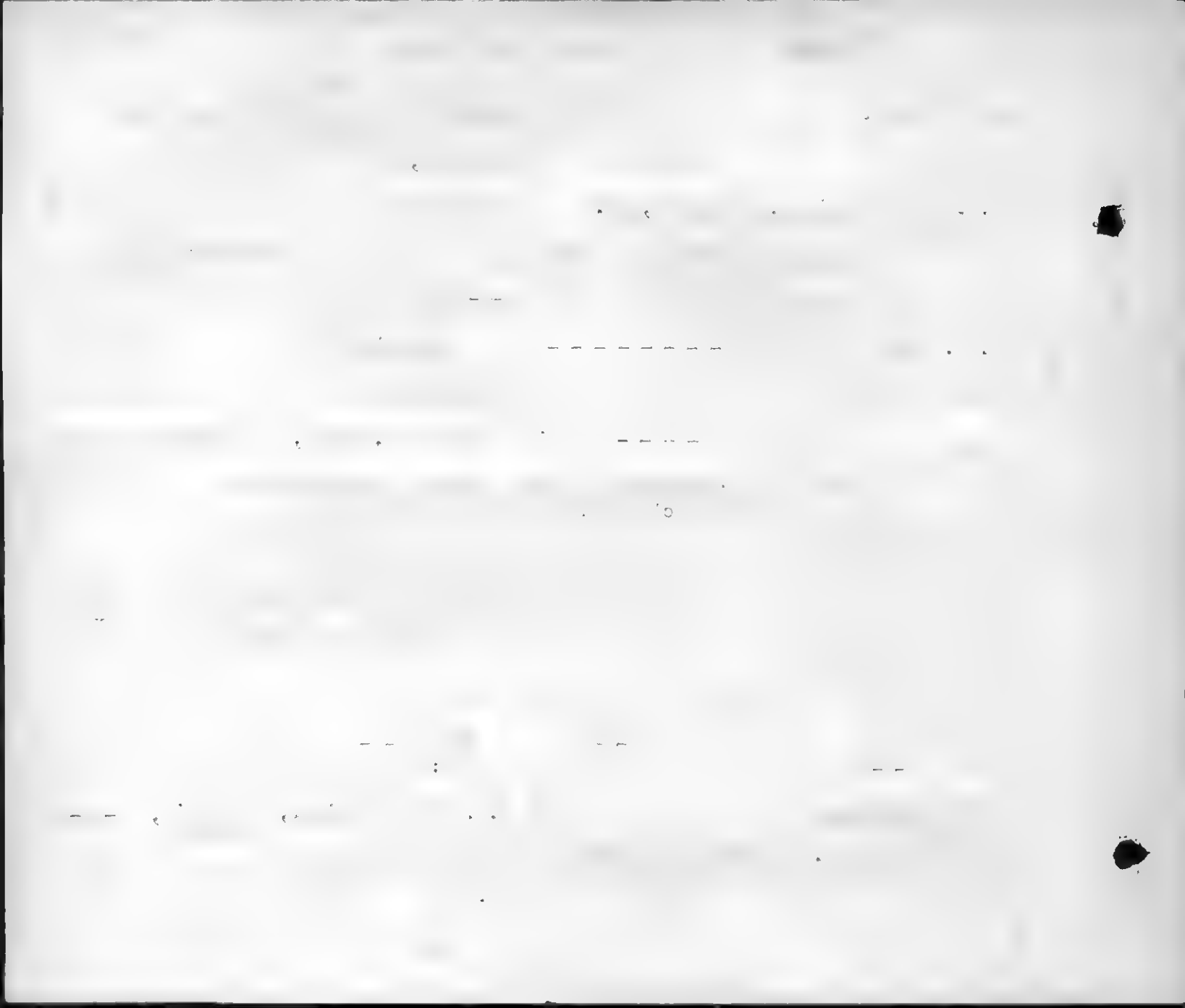
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND Anne Arundel				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission.) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 15 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Annapolis, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis,			
f. STREET ADDRESS 20 Southgate Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Leon Frederick BROWN				4. DATE OF DEATH Month Day Year September 9th 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-5-1894	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Connecticut		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alfred Brown				14. MOTHER'S MAIDEN NAME Hattie Hough			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO WW I and II		17. INFORMANT (wife) Eleanor M. Brown, 20 Southgate Avenue			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease and Cirrhosis DUE TO Laennec's with Hemorrhage and Coma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DUE TO } (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 9-6- 19 60 , to 9-9- 19 60 , that I last saw the deceased alive on 9-9-60 , 19 60 , and that death occurred at 6:03 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Annapolis, Maryland DATE SIGNED 9-10-60							
ACTUAL SIGNATURE John J. MC CANN M.D. U.S. Naval Hospital, Annapolis, Maryland							
PHYSICIAN'S NAME (Type) John J. MC CANN, LT MC USNR							
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county)	(State)			
Burial	Sept. 13-1960	U.S. Naval Academy	Annapolis	Md.			
23. FUNERAL DIRECTOR'S SIGNATURE John H. Taylor Sons			24a. REC'D BY REGISTRAR DATE SEP 13 '60	24b. REGISTRAR'S SIGNATURE Arthur E. Kinn			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9867

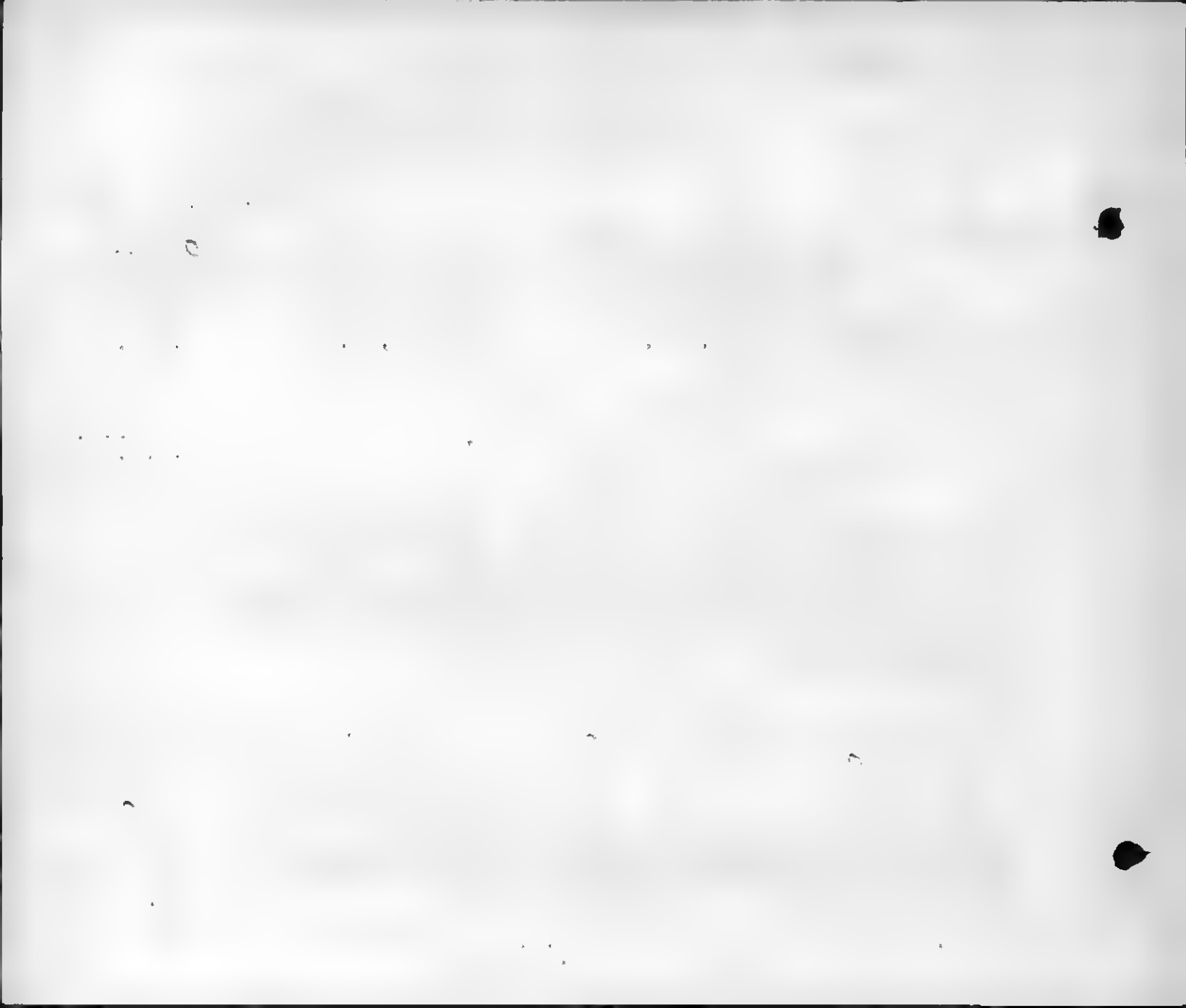
CERTIFICATE OF DEATH

Reg. Dist. No. 09841

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>?</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Hospital</u>				d. STREET ADDRESS <u>Apt. #309 1620 Fuller Street, N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Henry F. Buchanan</u> First Middle Last				4. DATE OF DEATH <u>9-04-1960</u> Month Day Year			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/22/1894</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>F.C.C.</u>		11. BIRTHPLACE (State or foreign country) <u>Charlotte, N.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Frank Buchanan</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Magill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW I</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Agnes L. Buchanan</u> Address <u>1620 Fuller St., N.W. Washington, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u>							<u>4 hr</u>
DUE TO <u>Coronary occlusion?</u>							<u>7 hr</u>
DUE TO <u>arteriosclerotic CVD</u>							<u>12 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-04-60</u> , 19 <u>60</u> to <u>9-04-60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>9-04-60</u> , and that death occurred at <u>9 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank M Shipley</u> M.D. <u>121 Cathedral St</u>				ADDRESS (Street, city or town, state) <u>9-04-60</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Frank M Shipley</u> <u>Annapolis, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>9/7/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>2901 14th St., N.W. Washington, D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

FOR STATE
HEALTH DEPT.

Item 18 Film 274 11-3-60 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 15842
9965 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Item 8 Film 274 11-3-60 et

1. PLACE OF DEATH
a. COUNTY A.A.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARYLAND
c. LENGTH OF STAY IN 1b 2 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pass one

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Same
b. COUNTY Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same
d. STREET ADDRESS Same

3. NAME OF DECEASED (Type or print) Ethor Margaret Lywater
4. DATE OF DEATH September 16th 1960
5. SEX F
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ B. DATE OF BIRTH 8/10/1897
8. AGE (in years last birthday) 63 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper and baby sitter
10b. KIND OF BUSINESS OR INDUSTRY Records found in her room
11. BIRTHPLACE (State or foreign country) Mt. Vernon, N.Y.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Charles Frederick Speidell
14. MOTHER'S MAIDEN NAME Maria Russell
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
16. SOCIAL SECURITY NO. 214-22-7409 H
17. INFORMANT Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I. of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

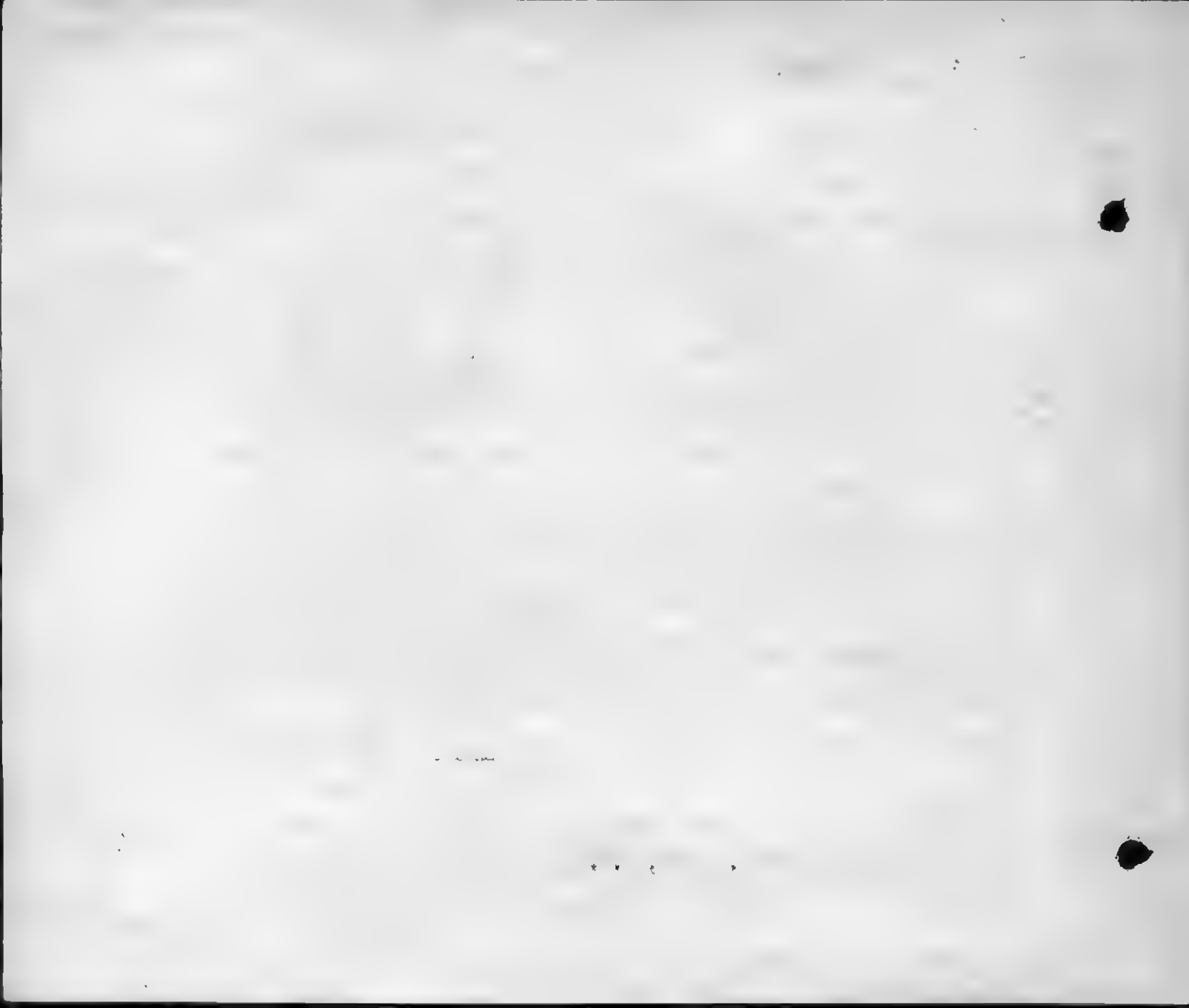
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
INTERVAL BETWEEN ONSET AND DEATH

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
CHIEF MEDICAL EXAMINER ☐
ASS. STANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county)

ACTUAL SIGNATURE Charles S. Petty M.D.
EXAMINER'S NAME (Type) Charles S. Petty, M.D.
DATE SIGNED 9/17/60

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 9-19-60
22c. NAME OF CEMETERY OR CREMATORY Glen Haven Maus.
22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.

23. FUNERAL DIRECTOR Hopping & Kirkner, Glen Burnie, Md.
24a. REC'D BY REGISTRAR SEP 20 '60
24b. REGISTRAR'S SIGNATURE Arthur S. Kline



9868

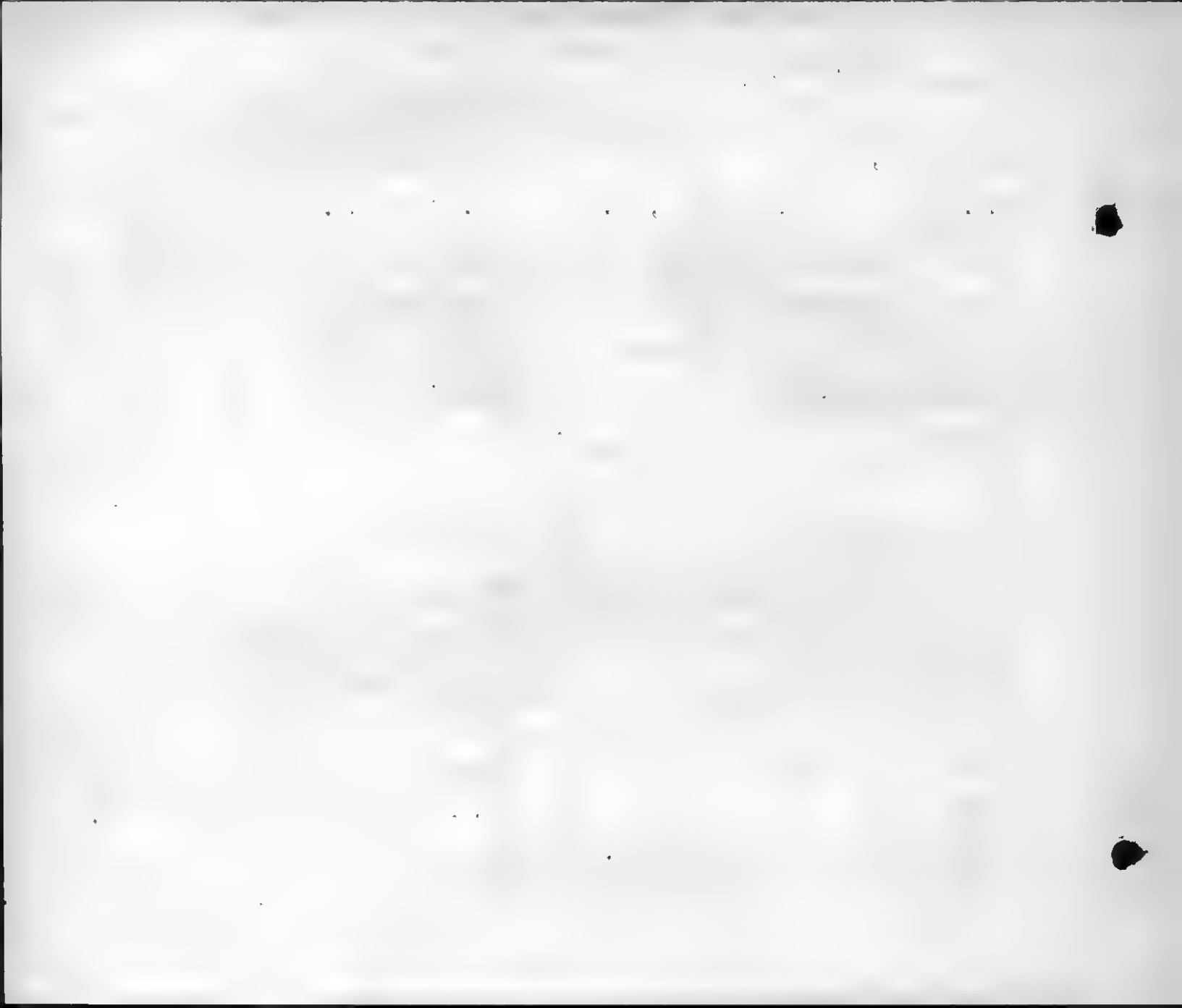
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE AURUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE AURUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Annapolis, Md.				d. STREET ADDRESS 311 N. Linden Ave.			
3. NAME OF DECEASED (Type or print) Luigi (n) CALABRESE				4. DATE OF DEATH Month SEPTEMBER Day 17 Year 1960			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 24 March 1894	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY Barber		11. BIRTHPLACE (State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown CALABRESE				14. MOTHER'S MAIDEN NAME Barbario LYIERCIO			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO.		17. INFORMANT Carmelina Marie Calabrese (2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of liver 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 16 September, 1960 , to 17 September 1960 , that I last saw the deceased alive on 17 September, 1960 , and that death occurred at 1:20 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 17 Sep 60 DATE SIGNED							
ACTUAL SIGNATURE Warren Jeffrey JONES Jr. LT MC USN				U.S. Naval Hospital, Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Sept 21-1960		St Marys		Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Saylor				24a. REC'D BY REGISTRAR DATE SEP 21 '60		24b. REGISTRAR'S SIGNATURE Charles S. K...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9908

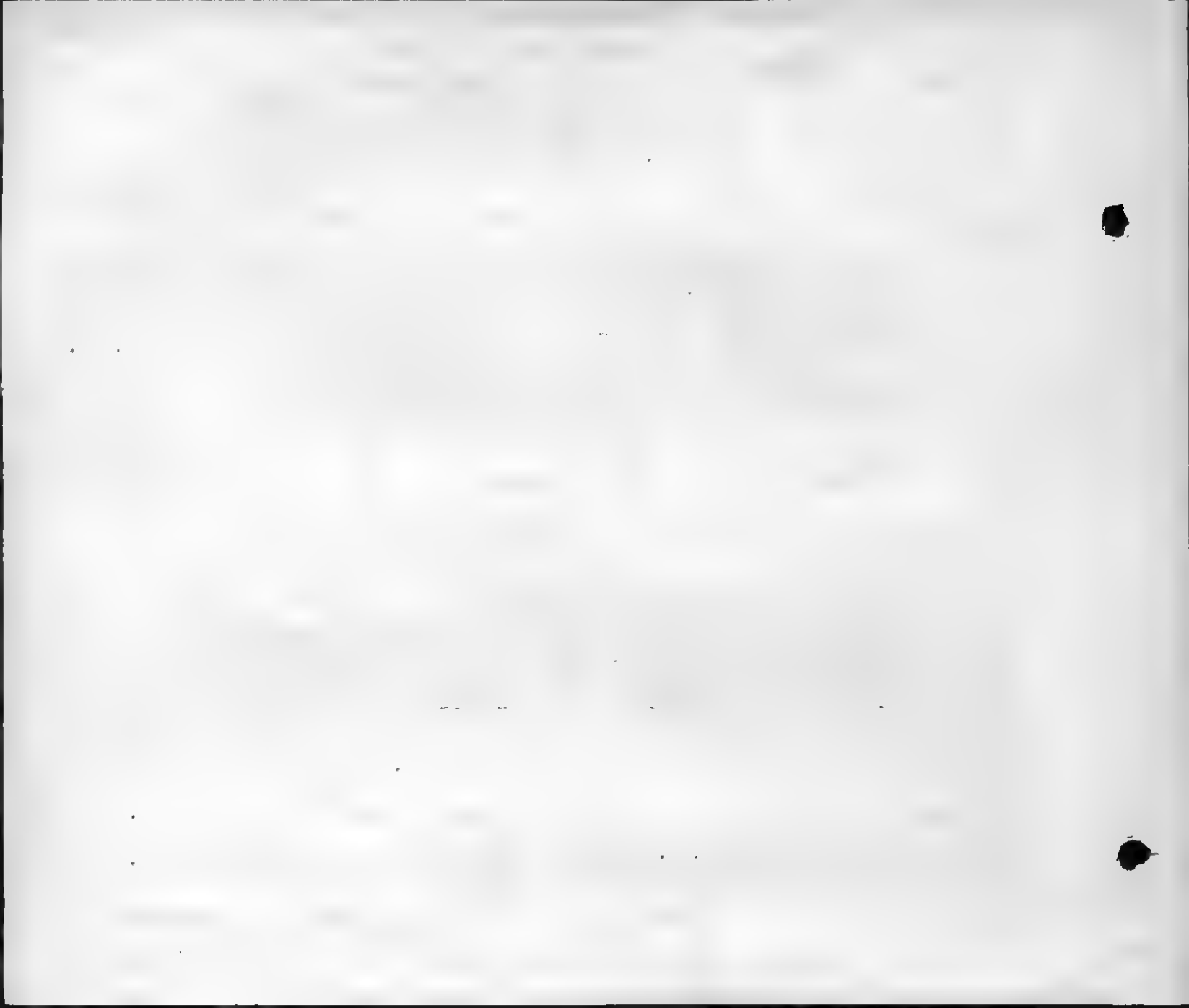
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 3mo. 24 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 3700 Calloway Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Helen Middle Clark Last Clark		4. DATE OF DEATH Month 9 Day 26 Year 19 60		5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1893		9. AGE (In years last birthday) yrs. 67		10. IF UNDER 1 YEAR Months 9 Days 26 Hours 19 Min. 60					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Stevenson		14. MOTHER'S MAIDEN NAME Caroline ?		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition and Dehydration 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Brain Syndrome DUE TO (c) Arteriosclerosis														INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) -----															
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. ----- 19				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----				20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 6/2 19 60 , to 9/26 19 60 , that I last saw the deceased alive on 9/26 19 60 , and that death occurred at 7:30A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Crownsville State Hospital, Md. 9/26/60																			
ACTUAL SIGNATURE L. Benedict, M. D.				M.D. Crownsville State Hospital, Md. 9/26/60				PHYSICIAN'S NAME (Type) L. Benedict, M. D.				M.D. Crownsville State Hospital, Md. 9/26/60							
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation				22b. DATE THEREOF 9/30/60				22c. NAME OF CEMETERY OR CREMATORY Unity of Maryland				22d. LOCATION (City, town, or county) (State) Baltimore Md							
23. FUNERAL DIRECTOR'S SIGNATURE William Reese				ADDRESS 108 W. Washington				24a. REC'D BY REGISTRAR OCT 3 '60				24b. REGISTRAR'S SIGNATURE William E. Reese							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9907

CERTIFICATE OF DEATH

09845

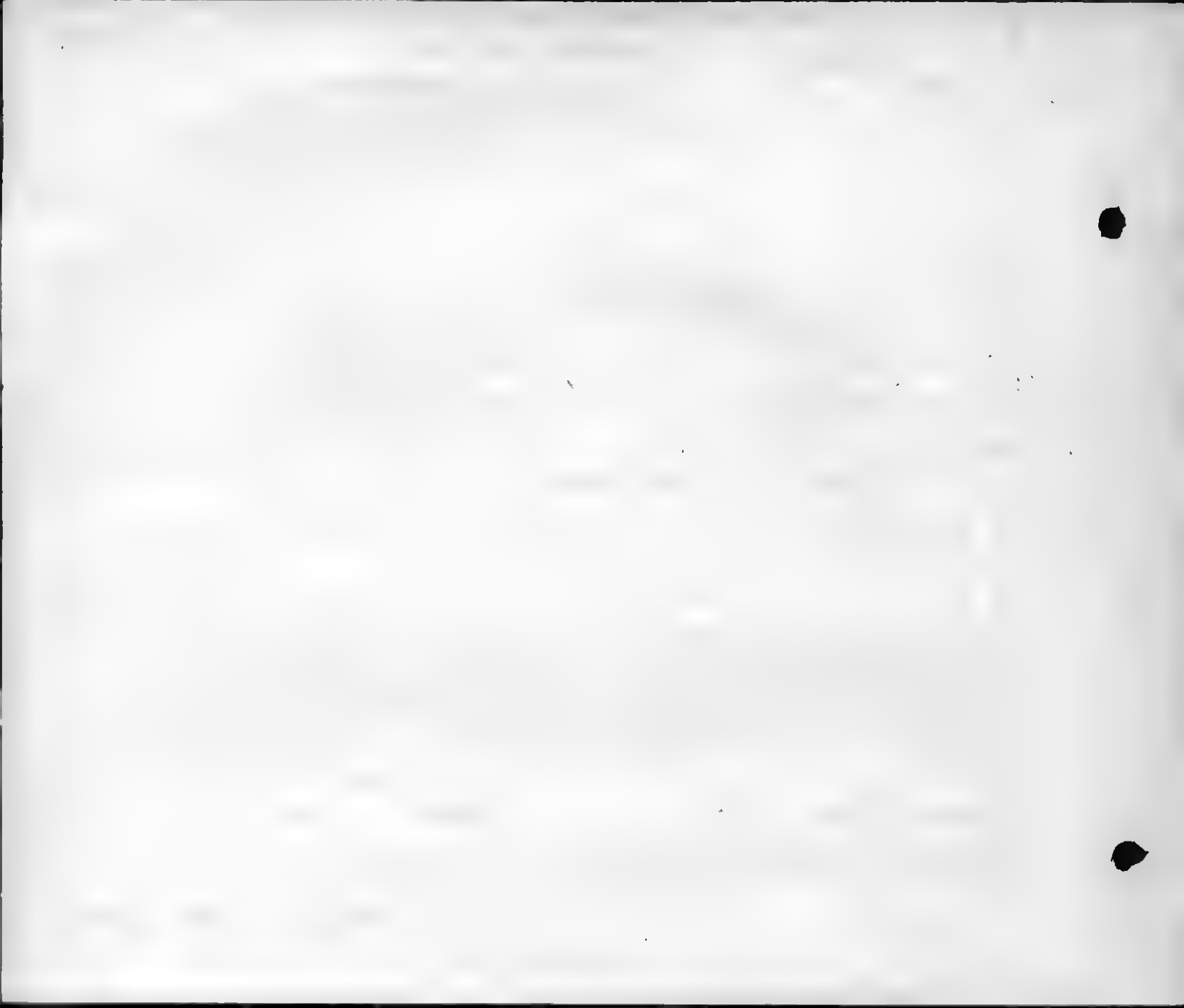
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Crownsville State Hosp.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN 1b <u>18 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Quantico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quantico</u> d. STREET ADDRESS <u>Rte. Box 154</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Marie</u> Last <u>Conway</u>				4. DATE OF DEATH Month <u>9</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/12/1918</u>	
9. AGE (In years last birthday) <u>42 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Wright</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Wright</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>11</u>		17. INFORMANT <u>Berry Conway</u> Address <u>113 First St. Solis and</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART FAILURE</u> <u>116X</u> DUE TO <u>RIGHT HEMIPLEGIA (CEREBRAL THROMBOSIS)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>RHEUMATIC HEART DISEASE</u> (c) <u>RHEUMATIC HEART DISEASE</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. m.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. Benedict M.D.</u>				DATE SIGNED <u>CROWNVILLE STATE HOSPITAL</u>			
PHYSICIAN'S NAME (Type) <u>L. BENEDICT M.D.</u>				ADDRESS <u>CROWNVILLE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/28/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Head Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Head Creek Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Christian F. ...</u> ADDRESS <u>...</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>...</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY		Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Fort George Meade		2 yrs.		b. COUNTY			
c. LENGTH OF STAY IN 1b						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Fort George Meade Hospital				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print)		Anne		Elizabeth		Craig		4. DATE OF DEATH	
5. SEX		Female		6. COLOR OR RACE		White		September 12 19 60	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		8/15/14		9. AGE (In years last birthday)		46 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Housewife		10b. KIND OF BUSINESS OR INDUSTRY		California		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		Edward Sickler		14. MOTHER'S MAIDEN NAME		Unk.		USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		No		16. SOCIAL SECURITY NO.		563-07-7535		17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Massive right subdural hemorrhage.		INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		Cirrhosis of liver					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. City or town (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER				DATE SIGNED		September 13, 1960	
ACTUAL SIGNATURE		Wm. J. [Signature]		M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type)						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)			
Cremation		9/17/60		Loudon Park		Baltimore, Md.			
23. FUNERAL DIRECTOR		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
Hopping and Kirkley		Glen Burnie, Md.		DATE		SEP 16 '60		[Signature]	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10955 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09847

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b _____		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pittsburgh</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>2325 Fairland Street</u>			
3. NAME OF DECEASED (Type or print) First <u>HUGH</u> Middle <u>S.</u> Last <u>CRONIN</u>				4. DATE OF DEATH Month <u>September</u> Day <u>6</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Feb. 13, 1908</u>		9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Life Insurance</u>		11. BIRTHPLACE (State or foreign country) <u>Boston, Mass.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Not Known</u>			
14. MOTHER'S MAIDEN NAME <u>Not Known</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>Michael P. Cronin</u>		Address <u>Pancroft Hall</u> <u>Annapolis, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable pulmonary tuberculosis</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			
20f. (City or town) _____		(County) _____		(State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>W. Bradley King, Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>9/7/60</u>			
EXAMINER'S NAME (Type) <u>W. Bradley King, Jr., M.D.</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Reburial</u>		22b. DATE THEREOF <u>9-9-1960</u>		22c. NAME OF CEMETERY OR CREMATORY _____			
22d. LOCATION (City, town, or county) <u>Boston</u>		(State) <u>Mass.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>John McBay & Sons</u>			
ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE SEP 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Kneass</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please state the reason therefor in the space provided. To the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. To the FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
TSM 9/59

1 *78*

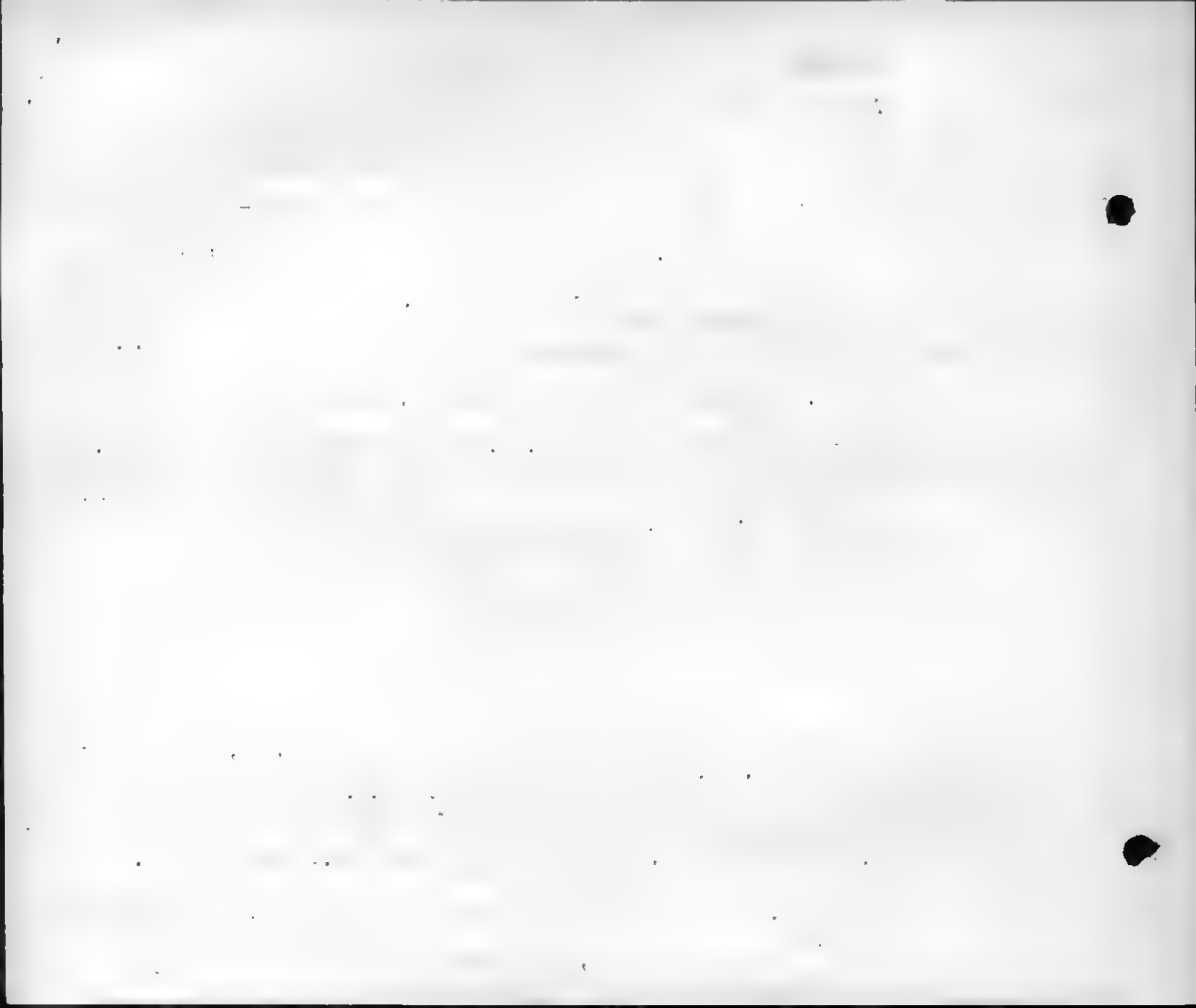
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
9869
CERTIFICATE OF DEATH

09848.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. STREET ADDRESS 237 Locust Grove Road, Rt-1			
3. NAME OF DECEASED (Type or print) First Dean Middle R. Last DRISCOLL				4. DATE OF DEATH Month September Day 20 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH December 22, 1897	9. AGE (In years lost birthday) 62 yrs	IF UNDER 1 YEAR Months Days Hours Min. 	IF UNDER 24 HRS Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician				10b. KIND OF BUSINESS OR INDUSTRY Self-Employed		11. BIRTHPLACE (State or foreign country) New Hampshire	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Michael B. Driscoll				14. MOTHER'S M maiden NAME Addie B. Robinson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no				16. SOCIAL SECURITY NO Unknown		17. INFORMANT Mr. D. Robert Driscoll Boyertown, Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Acute Hemorrhagic Pancreatitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) 				INTERVAL BETWEEN ONSET AND DEATH Hours 24 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Sept. 19, 1960 to Sept. 20, 1960				(County) (State)			
21. I certify that (I) deceased attended the deceased from Sept. 19, 1960 to Sept. 20, 1960 , that (I) was last saw the deceased alive on Sept. 20, 1960 , and that death occurred at 1:45 P.M. from the causes and on the date stated above.							
22a. SIGNATURE J. Fred Hawkins, Jr.				M. D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED Sept 20, 1960	
22c. PHYSICIAN'S NAME (Type) J. Fred Hawkins, Jr.				22d. ADDRESS 98 Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 26th Sept. 1960		23c. NAME OF CEMETERY OR CREMATORY Pine Grove Cemetery		23d. LOCATION (City, town, or county) (State) Manchester, New Hampshire	
24. FUNERAL DIRECTOR'S SIGNATURE Richard V. Singleton				ADDRESS Glen Burnie, Maryland		25a. REC'D BY REG STRAR DATE SEP 26 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. House			

MEDICAL CERTIFICATION

1



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 271 9-19-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

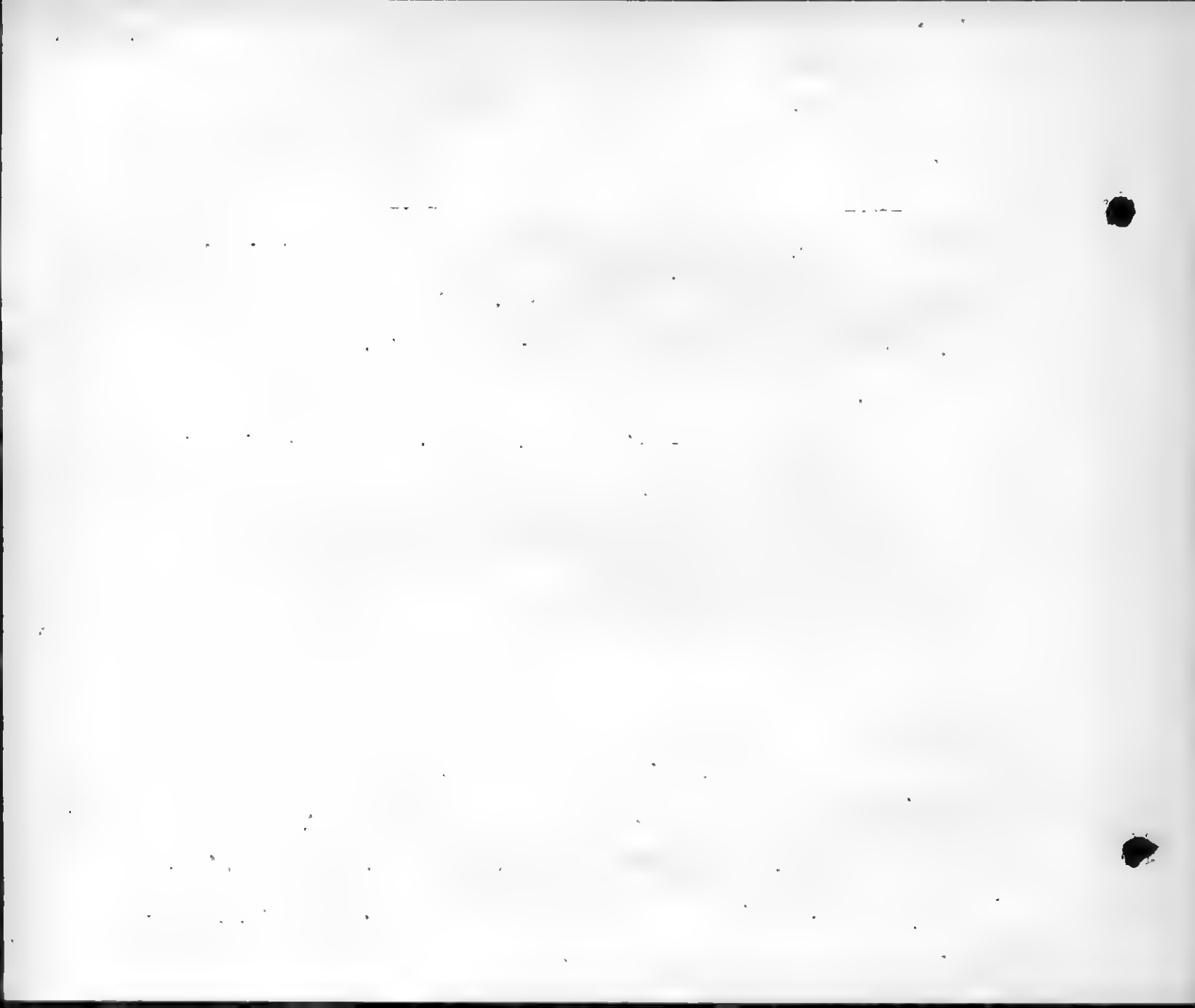
09849

9909

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater		c. LENGTH OF STAY IN 1b 1		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater		d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First SAMUEL		Middle TILDEN		Last EATON		4. DATE OF DEATH Month SEPT		Day 8		Year 19 60		5. SEX Male		6. COLOR OR RACE White									
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 7, 1877		9. AGE (In years last birthday) 83		10. UNDER 1 YEAR Months 83		10. UNDER 24 HRS Days 83		10. UNDER 24 HRS Hours 83		10. UNDER 24 HRS Min. 83		10. UNDER 24 HRS Min. 83									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building construction		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME A.J. Eaton		14. MOTHER'S MAIDEN NAME Mary Hook		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-16-9948		17. INFORMANT Mrs. Alice Leitch Eaton-Wife- same as # 2							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis		(b) Arteriosclerotic Cardio-Vascular		(c) Dissecting		INTERVAL BETWEEN ONSET AND DEATH 5 yrs		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5 yrs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 1, 1955 to Sept. 8, 1960 , that I last saw the deceased alive on Sept. 7, 1960 , and that death occurred at 8:45 A.M. , from the causes and on the date stated above		ACTUAL SIGNATURE Albert L. Anderson		M.D. Annablis		ADDRESS (Street, city or town, state) Southgate Ave., Annapolis, Maryland		DATE SIGNED 9/9/60		PHYSICIAN'S NAME (Type) Albert L. Anderson MD		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 10, 1960		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		22d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland		24a. REC'D BY REGISTRAR SEP 13 '60		24b. REGISTRAR'S SIGNATURE C. H. & H. H.	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		ADDRESS Annapolis, Maryland		24a. REC'D BY REGISTRAR SEP 13 '60		24b. REGISTRAR'S SIGNATURE C. H. & H. H.																	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9897

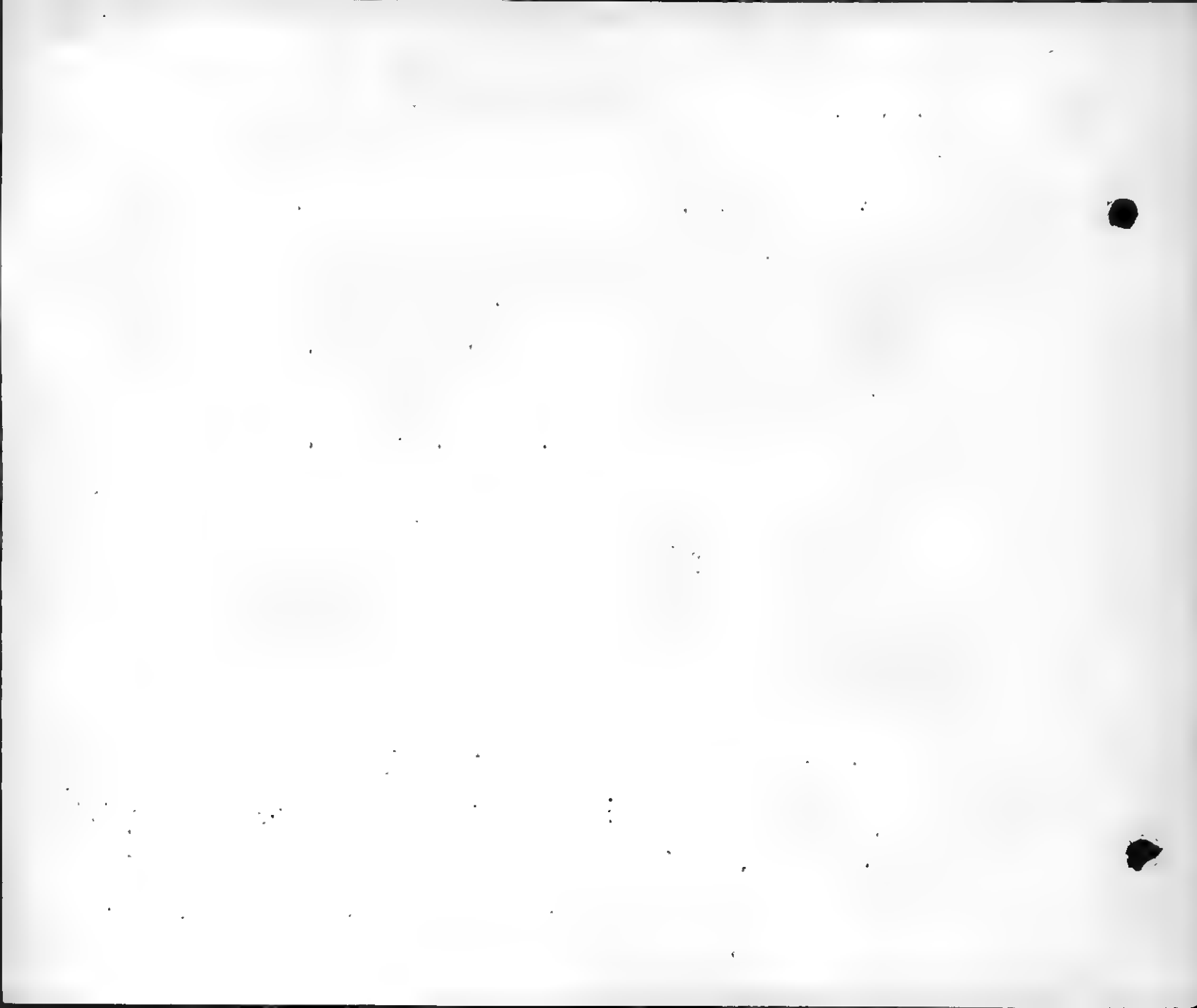
CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY A. A. Co. MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 2.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parole		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 731 Bowie Ave.		e. STREET ADDRESS Box 731 Bowie Ave.	
3. NAME OF DECEASED (Type or print) First Alice Middle Hall Last Ford		4. DATE OF DEATH Month September Day 5 Year 1960	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 4, 1909
9. AGE (In years last birthday) 50 yrs		10. IF UNDER 1 YEAR Months 50 Days 5 Hours 15 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		11b. KIND OF BUSINESS OR INDUSTRY Domestic	
11c. BIRTHPLACE (State or foreign country) Annapolis, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Ford		14. MOTHER'S MAIDEN NAME Luvonia ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Mr. James R. Brooks Jr., 121 Cherry Ct.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443X DUE TO Acute Pulmonary Edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease (c) Disease		INTERVAL BETWEEN ONSET AND DEATH 1 hour 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 5, 1960 to Sept 5, 1960 , that I last saw the deceased alive on Sept 5, 1960 , and that death occurred at 110-CLAY ST ANNAPOLIS , from the causes and on the date stated above.			
ACTUAL SIGNATURE R. Richardson		DATE SIGNED 9/7/60	
PHYSICIAN'S NAME (Type) R. Richardson M.D.		ADDRESS (Street, city or town, state) 110-CLAY ST ANNAPOLIS	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/8/60	
22c. NAME OF CEMETERY OR CREMATORY Pine Lawn Memorial Park		22d. LOCATION (City, town, or county) (State) Best Gate Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles F. Nicks III		24a. REC'D BY REGISTRAR SEP 13 '60	
ADDRESS 45 North West St. Annapolis, Md.		24b. REGISTRAR'S SIGNATURE Charles S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar or to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and remain event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9870

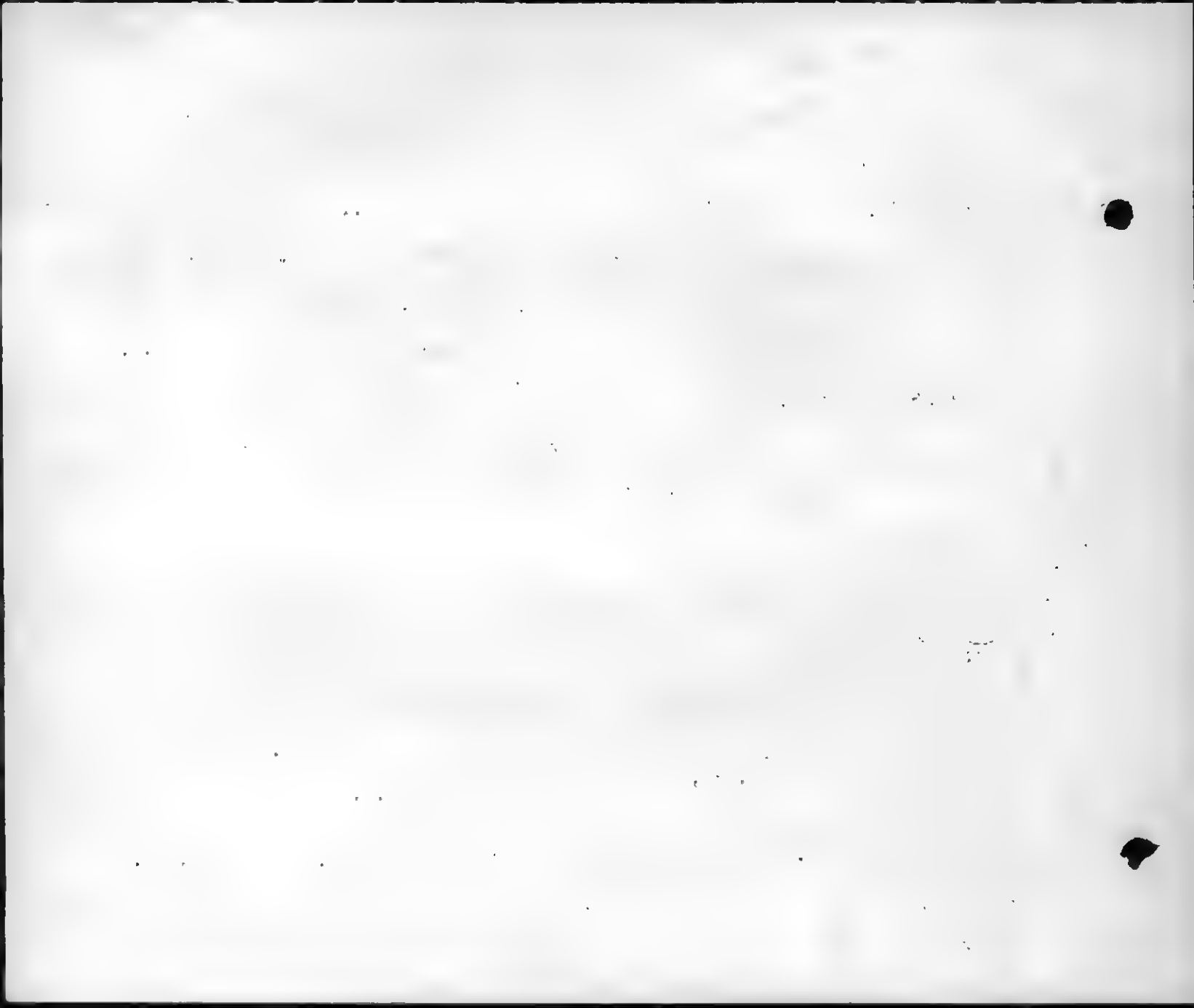
09851

1. PLACE OF DEATH a. COUNTY Anne Arundel				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. STREET ADDRESS 1202 Tyler Ave.,			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First Robert Middle H. Last GARDNER		4. DATE OF DEATH Month September Day 22 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 12, 1909		9. AGE (In years lost birthday) 50 yrs	10. IF UNDER 1 YEAR Months 50 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REFRIGERATION MECHANIC			10b. KIND OF BUSINESS OR INDUSTRY MECHANIC		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME MARSHALL H. GARDNER			14. MOTHER'S MAIDEN NAME DORA GROSS				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Helen Finckler Gardner Address 2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple sclerosis DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) physician attended the deceased from July 1956 , 19 _____ to Sept. 21, 1960 , that (I) had last saw the deceased alive on Sept. 21, 1960 , and that death occurred at _____ M, from the causes and on the date stated above							
22a. SIGNATURE John L. Hedeman		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/22/60			
22c. PHYSICIAN'S NAME (Type) John L. Hedeman		22d. ADDRESS 121 Cathedral St., Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 24 1960		23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cent		23d. LOCATION (City, town, or county) Annapolis Md (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sun				25a. REC'D BY REGISTRAR SEP 23 1960		25b. REGISTRAR'S SIGNATURE Arthur J. Hines	

(M)

063

1



1
FOR STATE
HEALTH DEPT.

TO DEPARTMENT OF HEALTH
This certificate should be completed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9871 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05852

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN It MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE [Where deceased lived, if institution: Residence before admission] a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchton d. STREET ADDRESS RURAL	
3. NAME OF DECEASED (Type or print) WILLIAM GARRETT		4. DATE OF DEATH September 27 1960	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1870
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waller's Helper	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) A.A. C. Hill	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Wilson Garrett	14. MOTHER'S MAIDEN NAME Finn Hill	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes W.W.T. UNKNOWN	
16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT MARIE LUCAS - A. Hill	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic and Hypertensive Heart Disease. DUE TO 4700 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. - DUE TO - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. a. -			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH -		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Partial	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty		M.D. Charles S. Petty, M.D.	
NAME (Type) Charles S. Petty, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/27/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10-3-60	22c. NAME OF CEMETERY OR CREMATORY U.S. Nat. Cem.	22d. LOCATION (City, town, or country) (State) Ann Arundel Co. Md.
23. FUNERAL DIRECTOR W. H. Hill		ADDRESS Annapolis, Md.	
24a. REC'D BY REGISTRAR OCT 10 '60		24b. REGISTRAR'S SIGNATURE Charles S. Petty	

MEDICAL CERTIFICATION

9898

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY 1			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riviera Beach				c. LENGTH OF STAY IN 1b 3 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 211 Lake Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Peter Middle TIMOTHY Last GARRIGAN				4. DATE OF DEATH Month SEPT Day 25 Year 1960			
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 19, 1872	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		10b. KIND OF BUSINESS OR INDUSTRY Budgings		11. BIRTHPLACE (State or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter Garrigan				14. MOTHER'S MAIDEN NAME —			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) —		16. SOCIAL SECURITY NO. —		17. INFORMANT Edward P. Garrigan Address 211 Lake Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO CONGESTIVE HEART FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO — (c) — DUE TO —							INTERVAL BETWEEN ONSET AND DEATH 12 HRS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) —					
20c. TIME OF INJURY Hour a.m. p.m. 19	Month 10	Day 11	Year 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) (County) (State) —	
21. I certify that I attended the deceased from 9/12/71 , 19 62 , to 1/25 , 19 60 , that I last saw the deceased alive on 1/27 , 19 62 , and that death occurred at 7:00 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3471 Fr. Sullivan Rd. Balto. Md. DATE SIGNED 1/25/60							
ACTUAL SIGNATURE J. P. Sullivan				DATE SIGNED 1/25/60			
PRINTED NAME (Type) J. P. Sullivan				ADDRESS 3471 Fr. Sullivan Rd. Balto. Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/1/60	22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Balto. Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Frankowski ADDRESS 2007 Eastern Ave.				24a. REC'D BY REGISTRAR DATE SEP 2 9 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hunt	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

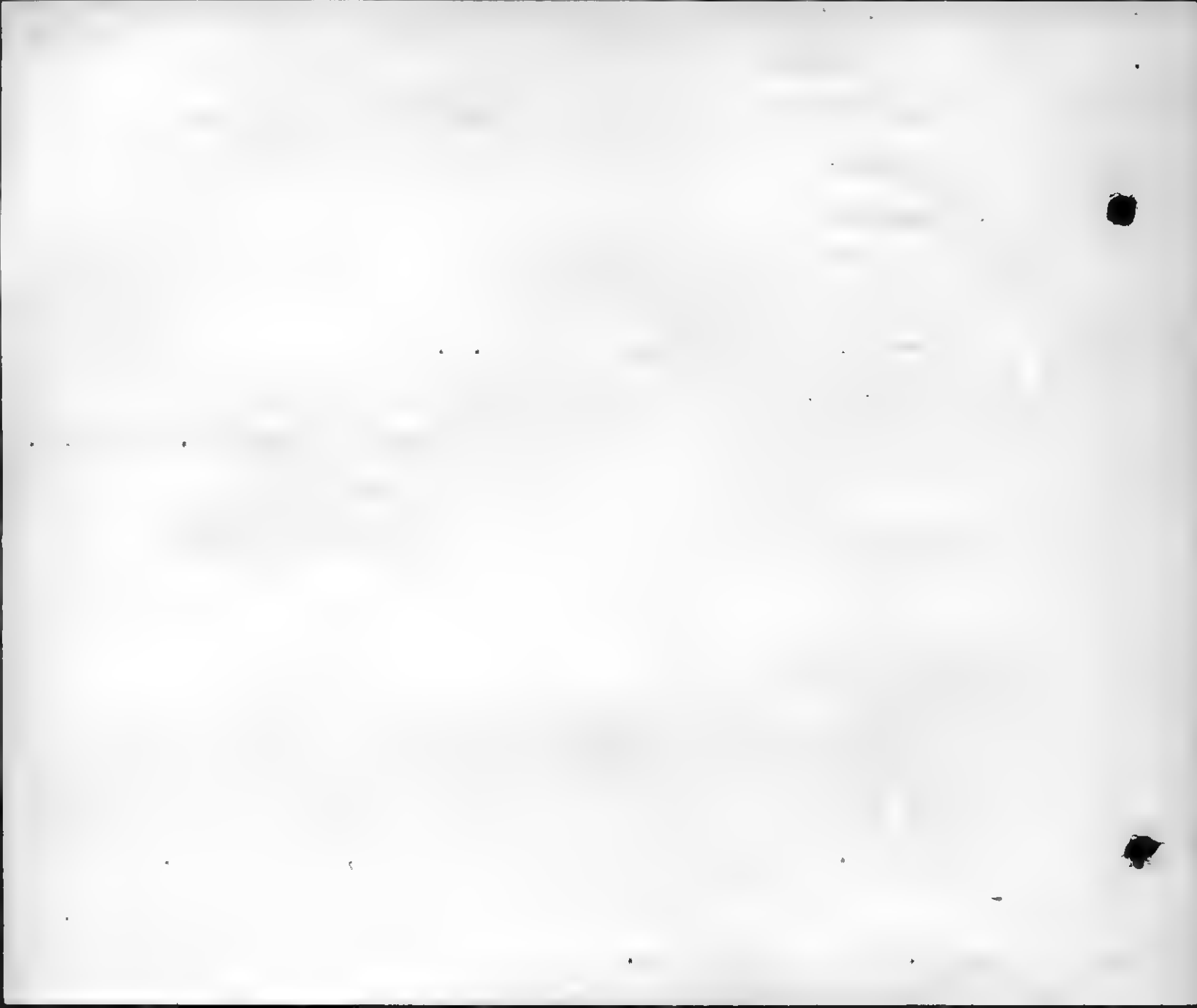
9872

CERTIFICATE OF DEATH

Reg. Dist. No.

09854

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Annapolis b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11 Pleasant Court		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sarah First Middle E Last Gross		4. DATE OF DEATH Month 9 Day 5 Year 19 60	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1871
9. AGE (In years lost birthday) 89 yrs		10. IF UNDER 1 YEAR Months 89 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) A. A. County		12. CITIZEN OF WHAT COUNTRY? A. A. County	
13. FATHER'S NAME Zedkiah Gross		14. MOTHER'S MAIDEN NAME Hattie Hardesty	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. THEODORE GROSS, 11 Pleasant Ct. Annapolis, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Thrombosis DUE TO (b) Arteriosclerotic Hypertensive Cardiac DUE TO (c) Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 0 m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 110 Clay St. Annapolis, Md.		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/4/60 to 9/5/60 , that I last saw the deceased alive on 9/4/60 , and that death occurred at 11:30 AM from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 110 Clay St. Annapolis, Md. DATE SIGNED 9/7/60	
ACTUAL SIGNATURE Dr. R. L. Richardson		M.D. 110 Clay St. Annapolis, Md.	
PHYSICIAN'S NAME (Type) Dr. R. L. Richardson		110 Clay St. Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Sept 8, 1960		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Pine Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Best Gate Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE James H. Johnson		ADDRESS Annapolis, Md.	
24a. REC'D BY REGISTRAR SEP 13 1960		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9873 CERTIFICATE OF DEATH

08855

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USNH, Annapolis, Maryland				d. STREET ADDRESS 410 Blossom Lane			
3. NAME OF DECEASED (Type or print) First Baby Boy Middle HALL Last				4. DATE OF DEATH Month September Day 18th Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-16-60		9. AGE (In years lost birthday) yrs. 0 Months 2 Days 12 Hours 15	IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Bernard Edward HALL				14. MOTHER'S MAIDEN NAME Gloria BERHEARD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Glen Burnie, Maryland Father - Bernard Edward HALL, 410 Blossom Lane			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxia 76.2.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atelectasis of Lungs DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH Since Birth							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anencephaly							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from 9-16-60 , 19 60 , to 9-18 , 19 60 , that I last saw the deceased alive on 9-13-60 , 19 60 , and that death occurred at 3:20 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) USNH, Annapolis, Maryland DATE SIGNED 9-19-60							
ACTUAL SIGNATURE N. L. ZOURAS		M.D. USNH, Annapolis, Maryland					
PHYSICIAN'S NAME (Type) N. L. ZOURAS, LT MC USNR		USNH, Annapolis, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Baltimore		22d. LOCATION (City, town, or county)		(State)	
23. FUNERAL HOME OR'S SIGNATURE Frank N. Fazio				ADDRESS 295 G. Greebe		24a. REC'D BY REGISTRAR DATE SEP 22 '60	
				24b. REGISTRAR'S SIGNATURE C. J. H. H. H.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be notified. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

9910

9856

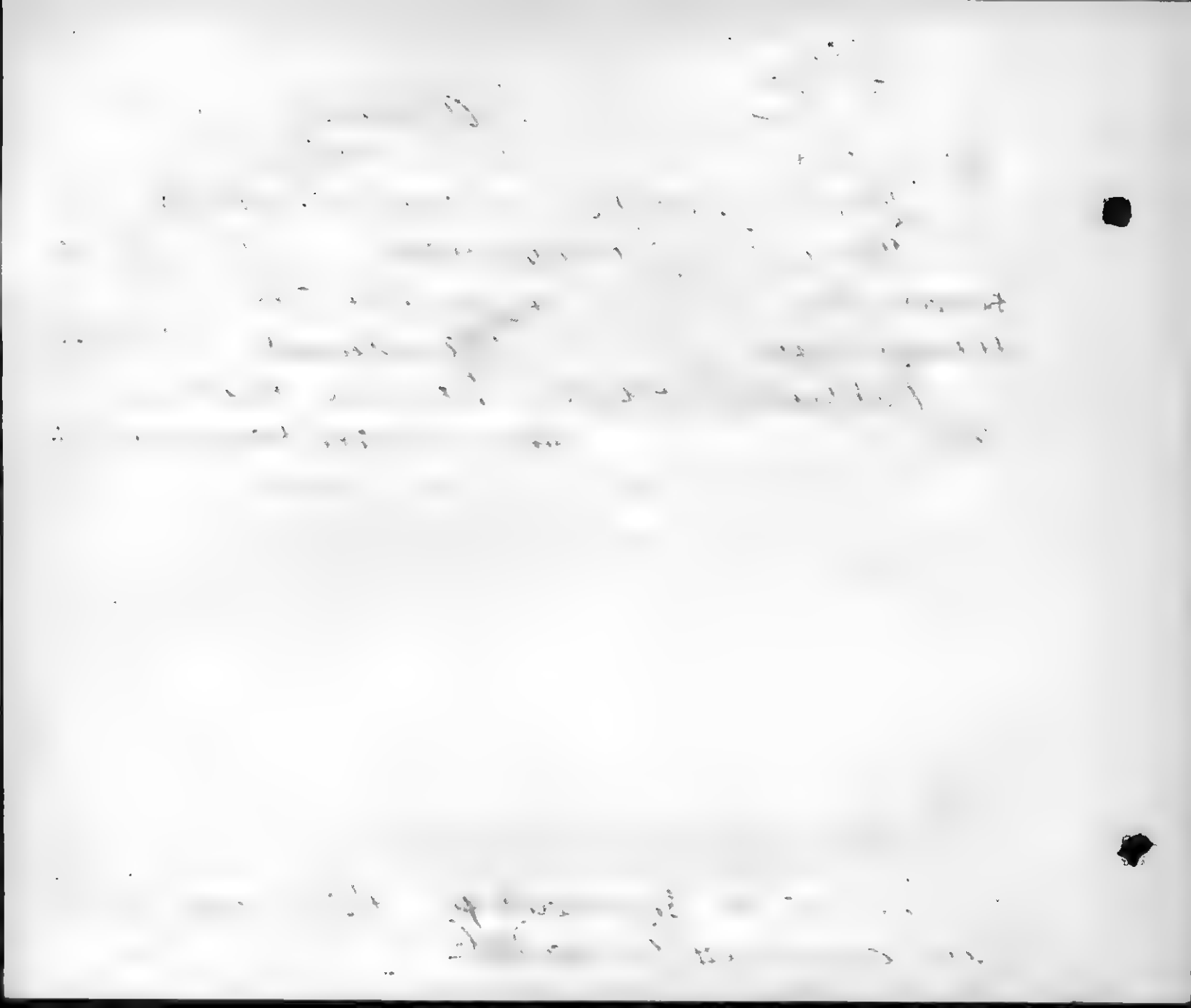
DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>A. A.</i> b. CITY OR TOWN (If outside corporate limits, write <i>Harwood</i> and give nearest town) c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. <i>Maryland</i> b. COUNTY <i>A. A.</i> c. CITY OR TOWN (If outside corporate limits, write <i>Harwood</i> and give nearest town) d. STREET ADDRESS <i>Muddy Creek Rd.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mary Ann E. Douglas Hall</i> First Middle Last 4. DATE OF DEATH <i>9-11-1960</i> Month Day Year		5. SEX <i>Female</i> 6. COLOR OR RACE <i>Col.</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <i>4-29-1884</i> 9. AGE (In years last birthday) <i>76</i> yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>William Douglas</i> 14. MOTHER'S MAIDEN NAME <i>Louise Harris</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <i>James S. Hall</i> 17. INFORMANT <i>Harwood Md.</i> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Pulmonary Edema</i> DUE TO <i>Chronic Pulmonary Hypertension</i> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost <i>Vascular disease grade III</i> DUE TO (b) <i>2 years</i> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>2 years</i> INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <i>5/11/58</i> to <i>9/11/60</i> , that (I) (we) last saw the deceased alive on <i>9/11/60</i> 19____, and that death occurred at <i>5:11 A.M.</i> from the causes and on the date stated above. 22a. SIGNATURE <i>R. L. Richards</i> M.D. ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <i>R. L. RICHARDS, M.D.</i> 22d. ADDRESS <i>110-CLAY ST. HARWOOD, MD.</i> 22b. DATE SIGNED <i>9/13/60</i>	
23a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> 23b. DATE THEREOF <i>9-15-1960</i> 23c. NAME OF CEMETERY OR CREMATORY <i>Friendship</i> 23d. LOCATION (City, town, or county) (State) <i>Harwood Md.</i>		24. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese Anna Md.</i> ADDRESS 25a. REC'D BY REGISTRAR <i>SEP 19 '60</i> 25b. REGISTRAR'S SIGNATURE <i>William E. Kenna</i>	

(M)

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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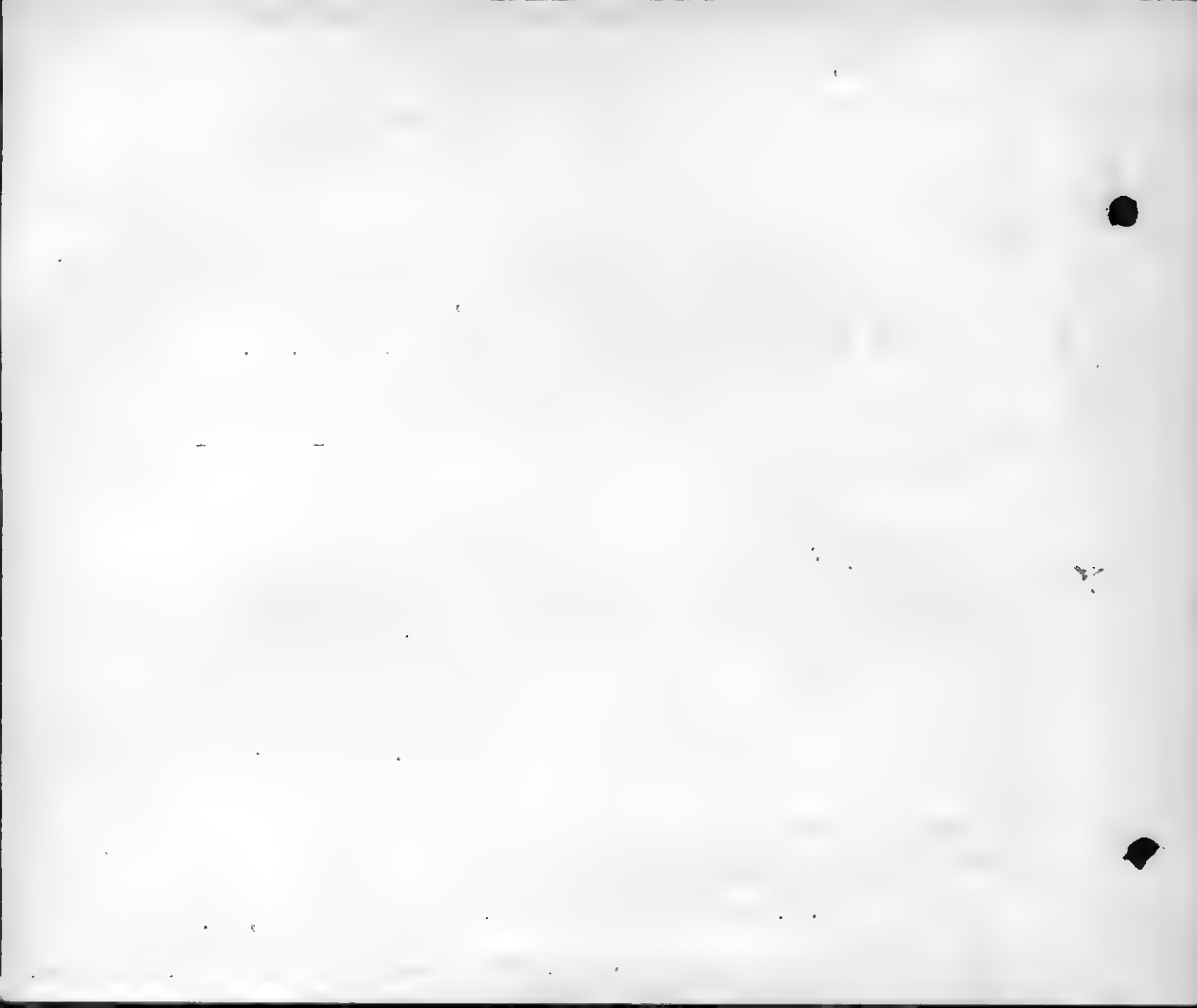
CERTIFICATE OF DEATH

09857

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riva		c. LENGTH OF STAY IN 1b Rural Annapolis		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mannor Guest Home				d. STREET ADDRESS (Thomas Point)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELSIE M HAMBRUCH		4. DATE OF DEATH Month September Day 27 Year 19 60		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 28, 1888		9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Baltimore, County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Cox				14. MOTHER'S MAIDEN NAME Frances Thompson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO none		17. INFORMANT Mrs Louis Stevens Sr.- Daughter- same as # 2 Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APRIL 1960 to 27 SEPT. 1960 , that I last saw the deceased alive on 27 SEPT. 1960 , and that death occurred at 2:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 21 Franklin St. Annapolis, Md. DATE SIGNED 9/28/60							
ACTUAL SIGNATURE Edward Beck		M.D.					
PHYSICIAN'S NAME (Type) Edward Beck MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 30, 1960		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home ADDRESS Annapolis, Maryland				24a. RECEIVED BY REGISTRAR SEP 30 1960 DATE SEP 30 1960		24b. REGISTRAR'S SIGNATURE William L. Haines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

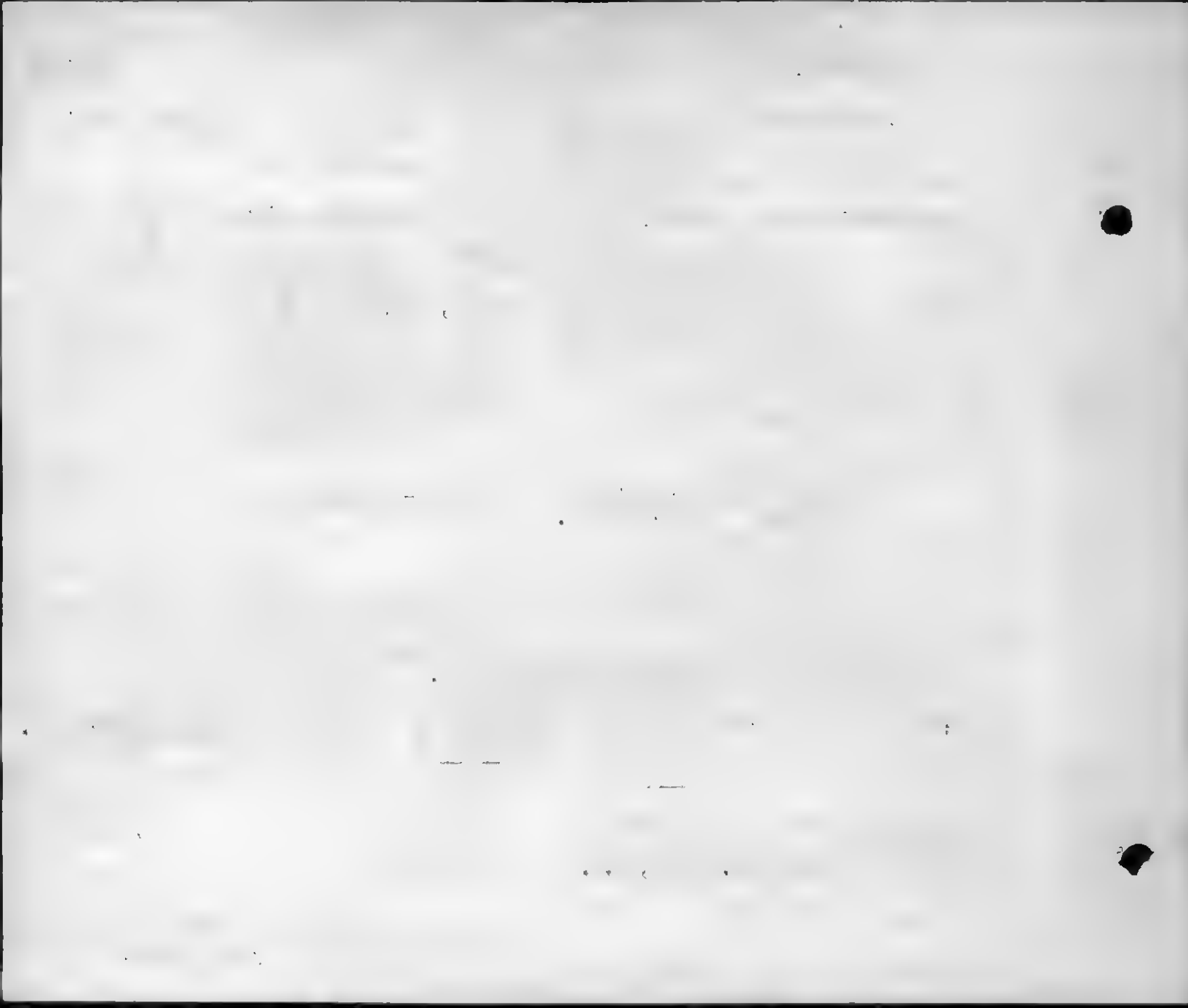
9874 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09858

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital			d. STREET ADDRESS 306 Rogers Heights		
3. NAME OF DECEASED (Type or print) MARCIA ANN HANEKE			4. DATE OF DEATH September 26 19 60		
5. SEX Female			6. COLOR OR RACE White		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED			8. DATE OF BIRTH July 24, 1957		
9. AGE (In years, if UNDER 1 YEAR, IF UNDER 24 HRS. last birthday) 3 yrs.			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		
11. BIRTHPLACE (State or foreign country) Annapolis Md			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William L. Haneke			14. MOTHER'S MAIDEN NAME Alice I. Carr		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. —		
17. INFORMANT James A. Murchake			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Stomach during Post-operative care for Tonsillectomy. 955X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DOESX DUE TO (b) DOESX (c) DOESX		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Therapeutic Misadventure.			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. Therapeutic Misadventure.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year 3:00 p.m. 9/26 19 60			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital			20f. (City or town) Annapolis (County) Anne Arundel (State) Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Petty			DATE SIGNED 9/27/60		
EXAMINER'S NAME (Type) Charles S. Petty, M.D.			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF Sept 29-60		
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial			22d. LOCATION (City, town, or country) Annapolis Md		
23. FUNERAL DIRECTOR Joan M. Taylor Sons			24a. REC'D BY REGISTRAR SEP 29 '60		
ADDRESS Annapolis Md			24b. REGISTRAR'S SIGNATURE Arthur J. Kraus		

MEDICAL CERTIFICATION

2



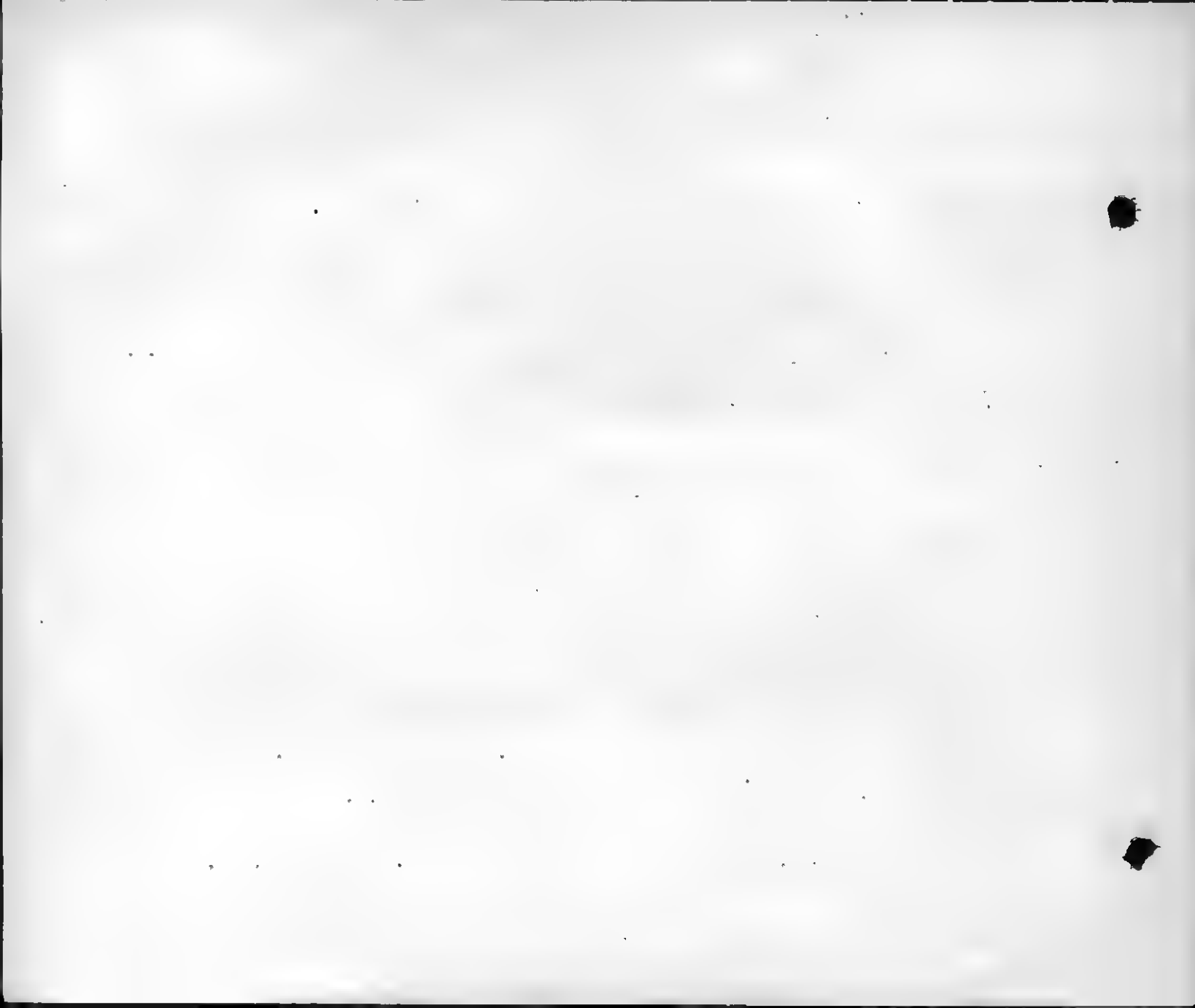
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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9875
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09859

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 5 Martin St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First Douglas Middle M. Last HIPKINS				4. DATE OF DEATH Month September Day 29 Year 1960											
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 22, 1907		9. AGE (In years last birthday) 52 yrs		10. IF UNDER 1 YEAR Months 2 Days 1		11. IF UNDER 24 HRS Hours 4 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber				10b. KIND OF BUSINESS OR INDUSTRY Naval Academy				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Charles E. Hipkins				14. MOTHER'S MAIDEN NAME Catherine Wilson											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO -				17. INFORMANT Address Capitola L. Hipkins (2)							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Coma 157x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hepatic Failure DUE TO (c) Tumor of Pancreas (Carcinoma?) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 days 2 wks 1 4 wks 1												INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) the physician attended the deceased from Aug. 28, 1960 to Sept. 29, 1960 that (I) last saw the deceased alive on Sept. 29, 1960 , and that death occurred at 8:20 P.M. from the causes and on the date stated above.															
22a. SIGNATURE James R. Martin				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 9/30/60							
22c. PHYSICIAN'S NAME (Type) James R. MARTIN				22d. ADDRESS 6 Shaw St., Annapolis, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Oct 3-1960		23c. NAME OF CEMETERY OR CREMATORY Marys Memorial				23d. LOCATION (City, town or county) (State) Marys Md					
24. ELDERA. DIRECTOR'S SIGNATURE John M. Taylor Sr				ADDRESS Annapolis Md				25a. REC'D BY REGISTRAR DATE OCT 3 '60				25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			



may be filled by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director should be present at the time the certificate is signed. After this certificate has been signed by the attending physician and completely filled, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

FilemG273 12-1-50 et

9912

CERTIFICATE OF DEATH

Reg. Dist. No. 00860

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>AA (E)</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crump</u>		c. LENGTH OF STAY IN 1b <u>27 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Mary's Hospital, Crump</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James R Hipsley</u>		4. DATE OF DEATH <u>9-27-1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-27-1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>?</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>	
11. BIRTHPLACE (State or foreign country) <u>Cooksville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Hipsley</u>		14. MOTHER'S MAIDEN NAME <u>Annie Hipsley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>?</u>		Address <u>?</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>Hypertensive arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular disease</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-14</u> , 19 <u>60</u> , to <u>9-27</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>9-21</u> , 19 <u>60</u> , and that death occurred at <u>9-27</u> , 19 <u>60</u> , M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Crump, Md.</u> DATE SIGNED <u>9-28-60</u>	
ACTUAL SIGNATURE <u>Jose M. Yosunico</u> M.D.		PHYSICIAN'S NAME (Type) <u>Jose M. Yosunico, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>?</u>		22b. DATE THEREOF <u>9-30-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>?</u> ADDRESS <u>?</u>		24a. REC'D BY REGISTRAR <u>?</u> 24b. REGISTRAR'S SIGNATURE <u>?</u>	



9876

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09861

(M)

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL- Gambrills	
3. NAME OF DECEASED (Type or print) First Lydia Middle C. Last HOBBS		4. DATE OF DEATH Month September Day 3 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 23, 1884
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min 76	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. KIND OF BUSINESS OR INDUSTRY None	
13. BIRTHPLACE (State or foreign country) Kentucky		14. CITIZEN OF WHAT COUNTRY? U.S.	
15. FATHER'S NAME JIMMIE LEE		16. MOTHER'S MAIDEN NAME JINCY SALLOR	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		18. SOCIAL SECURITY NO. None	
19. INFORMANT Mrs Curtis Lee		Address (2)	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac. Pulmonary Edema 4-25-1 DUE TO Ac. Myocardial Infarction Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) DUE TO (c) Ac. Myocardial Infarction			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Essential Myocardial Infarction - (1 mo. ago)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (physician) attended the deceased from Sept. 2, 1960 to Sept. 3, 1960 , that (I) yes last saw the deceased alive on Sept. 3, 1960 , and that death occurred at 1:25 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Maurice Klawans M.D.		22b. DATE 9/4/60	
22c. PHYSICIAN'S NAME (Type) Maurice Klawans		22d. ADDRESS 31 Southgate Ave., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-6-1960	
23c. NAME OF CEMETERY OR CREMATORY Church of God Cemetery		23d. LOCATION (City, town, or county) (State) Gambrills Md	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons		25a. REC'D BY REGISTRAR SEP 7 '60	
ADDRESS Annapolis Md		25b. REGISTRAR'S SIGNATURE Curtis S. Kraws	

F.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9877 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08862

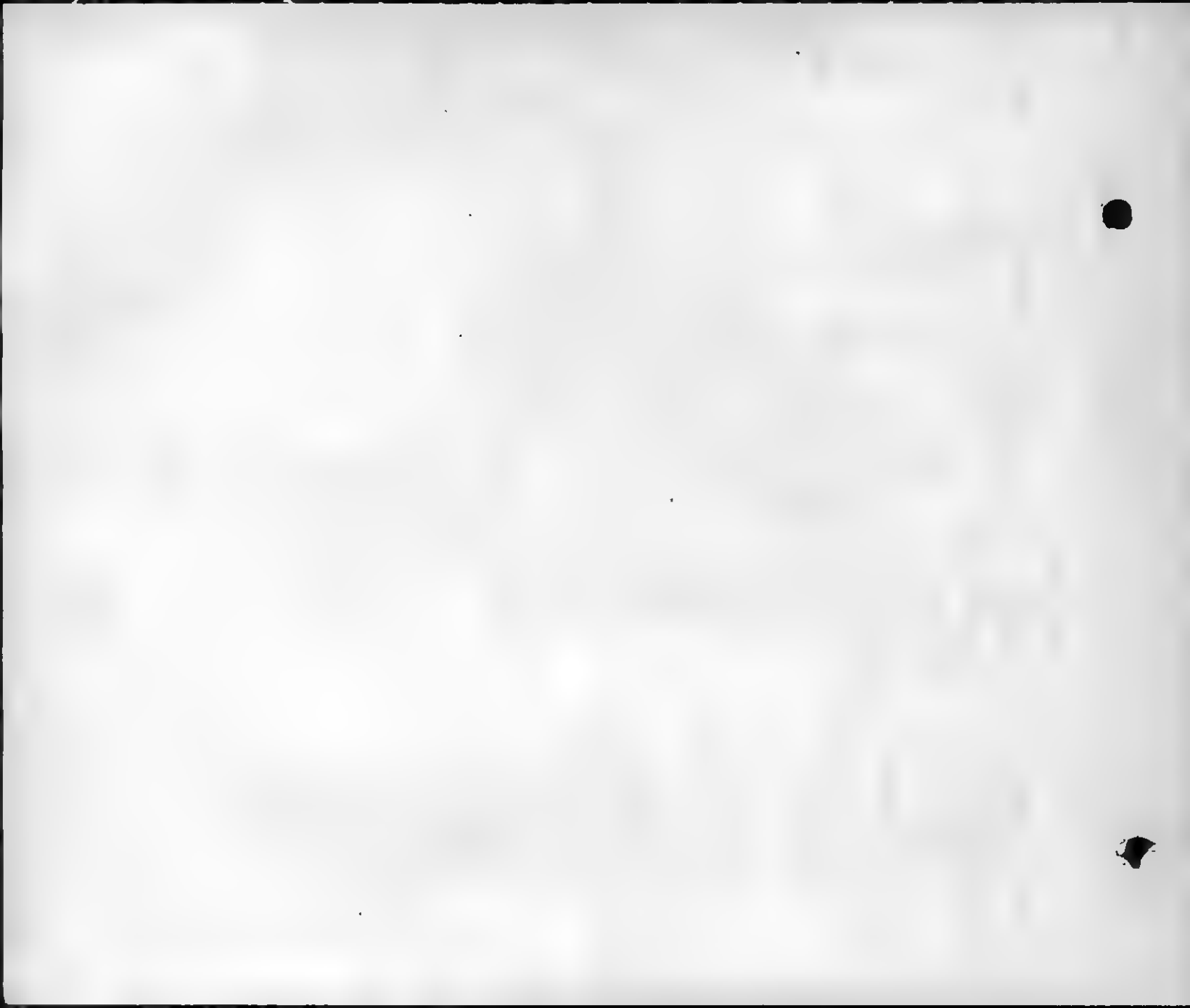
Reg. Dist. No.

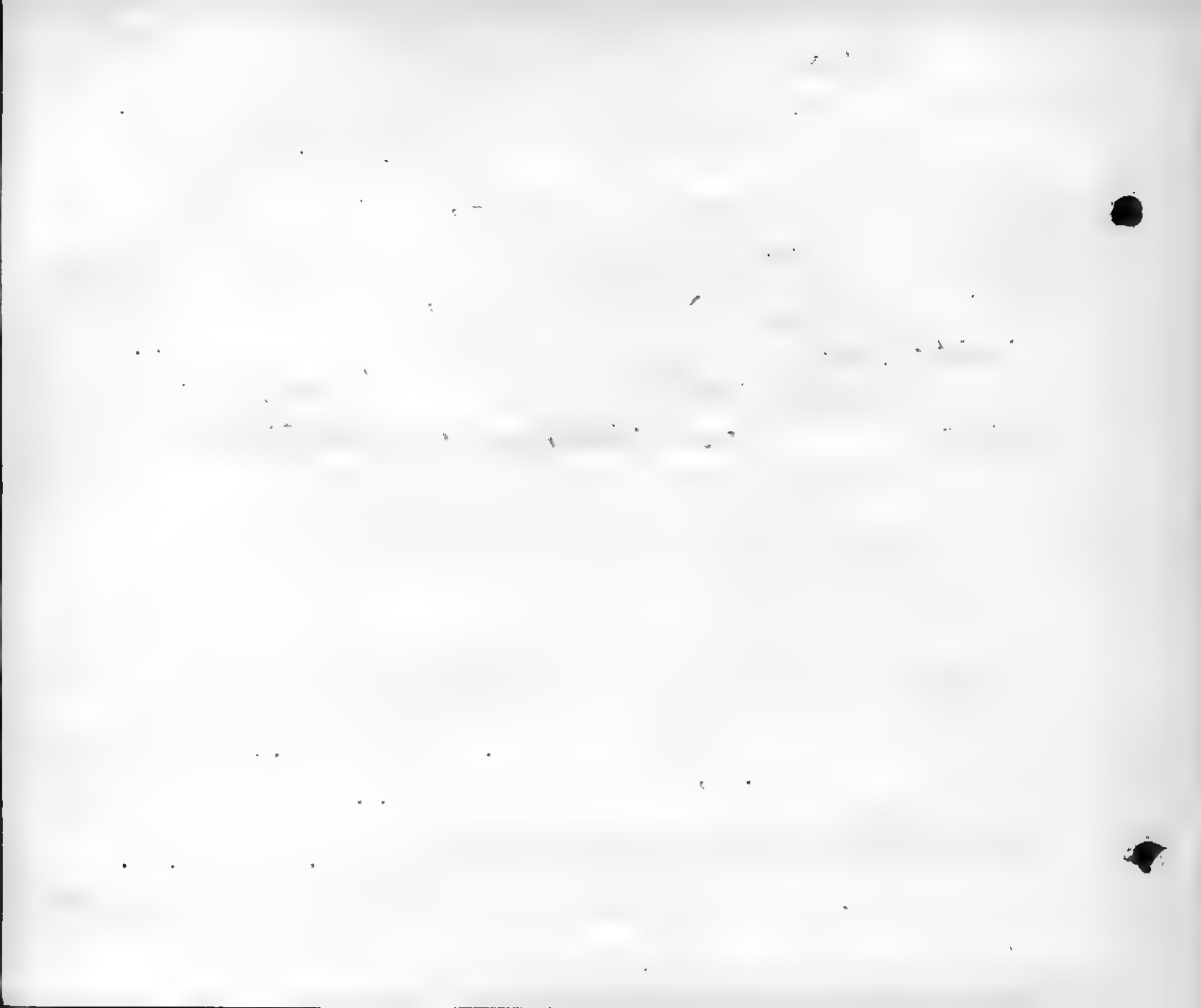
1. PLACE OF DEATH a. COUNTY <u>HAVE ARUND</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A.Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>614 BURNSIDE ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>FLORENCE V. HOFFMAN</u>				4. DATE OF DEATH Month <u>9</u> Day <u>4</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-14-1876</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>W. PRES. + PARTNER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BUS CO.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>EMIL A. HARTGE</u>				14. MOTHER'S MAIDEN NAME <u>SUSAN EDGAR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>C. GILBERT HOFFMAN</u> Address <u># 2</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> (b) <u> </u> (c) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u> </u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year <u>9.4 1960</u> Hour a. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. Linhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>9-7-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>QUAKER BURNING GROUND</u>	
22d. LOCATION (City, town, or county) <u>GALESVILLE</u>				(State) <u>MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. L. L. & Sons Annapolis, Md.</u>				24a. REC'D BY REGISTRAR <u>SEP 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for to burial, cremation, or removal.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

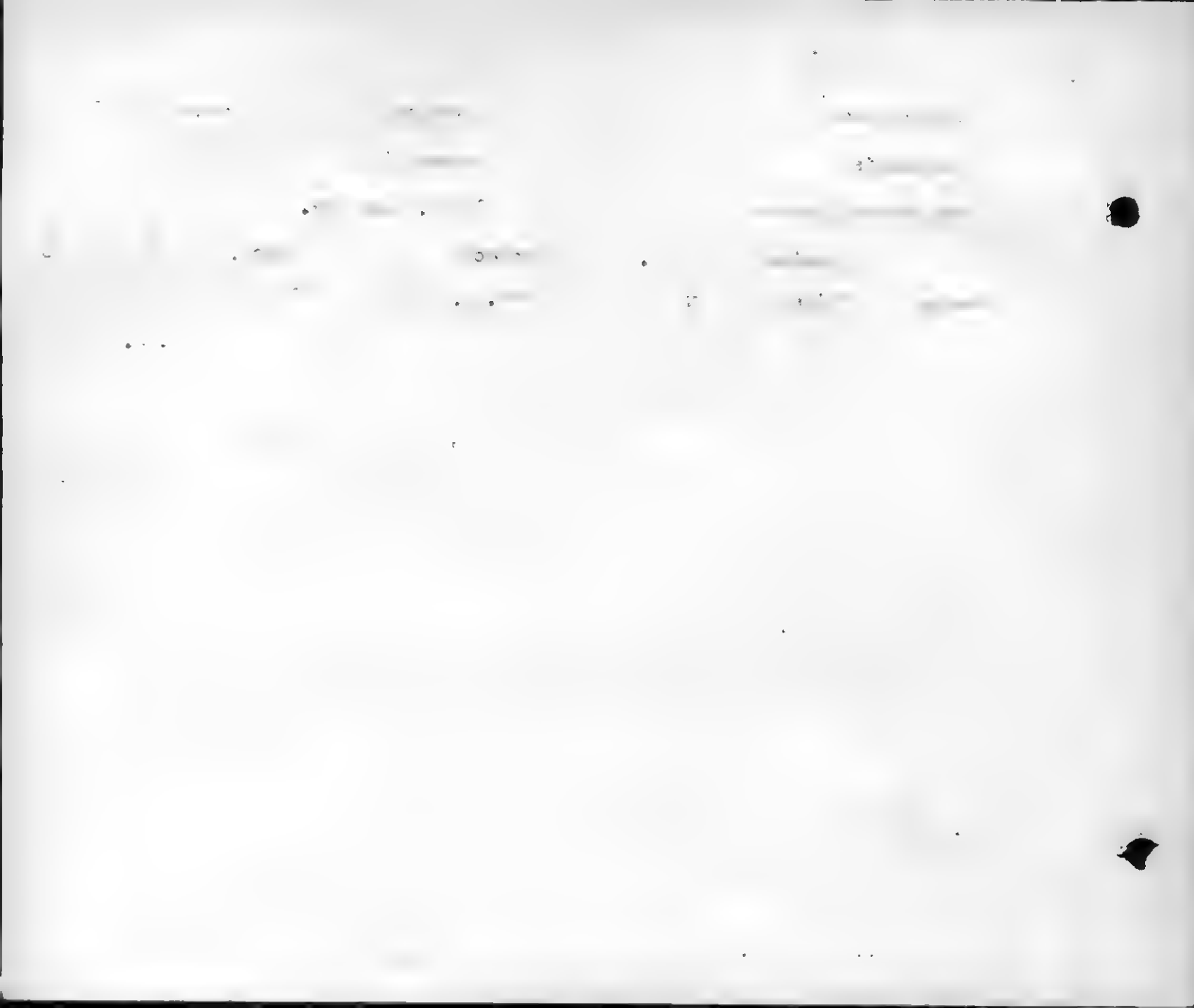
VR A15 (4)
ISM 9/59

1
9879
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09864

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institut on: Residence before adm ssion) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General				d. STREET ADDRESS 312 N. Glen Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Louisa Middle T. Last Hucksell				4. DATE OF DEATH Month Sept. Day 16 Year 19 60			
5. SEX Female		6 COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Oct. 5, 1878	
9 AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 81 Days 81 Hours 81 Min.		IF UNDER 24 HRS. Months 81 Days 81 Hours 81 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME Michael Bridinger				14. MOTHER'S MAIDEN NAME Nora (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO		17 INFORMANT Address Nora Nash, 886 West Lombard Street	
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) EMPIEMA, LEFT THORAX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PNEUMONIA, LEFT LOWER LOBE DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 4 DAYS 4 DAYS			
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) DIABETES MELLITUS				19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21 I certify that (I) (this hospital) attended the deceased from 9-6-1960 to 9-16-1960 , that (I) (we) last saw the deceased alive on 9-16-1960 , and that death occurred at 7:30 PM , from the causes and on the date stated above.							
22a SIGNATURE Edward H. Cook M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED 9/17/60	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9-21-60		23c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery		23d LOCATION (City, town, or county) (State) Woodlawn, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street				ADDRESS		25a. REC'D BY REGISTRAR DATE SEP 20 '60	
				25b REGISTRAR'S SIGNATURE Arthur S. Hume			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. This page should be removed from the carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

98880

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10966

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 19 hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Leroy Middle HUMMER Last HUMMER				4. DATE OF DEATH Month September Day 30 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 18, 1897	
9. AGE (In years last birthday) 63 yrs		F UNDER 1 YEAR Months 63 Days 63 Hours 63 Min. 63		10. KIND OF BUSINESS OR INDUSTRY CARPENTER		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.				13. FATHER'S NAME FRANCIS H. HUMMER			
14. MOTHER'S MAIDEN NAME ROSE FAIR BANK				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes			
16. SOCIAL SECURITY NO. W.W.I. 112-09-8600				17. INFORMANT MRS. DOROTHY LEDNUM Address TILGHMAN MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterior myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 24 hr							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that (I) this hospital attended the deceased from Sept. 30, 1960 to Sept. 30, 1960 , that (I) yes last saw the deceased alive on Sept. 30, 1960 , and that death occurred at 7:30 P.M. M. from the causes and on the date stated above.							
22a. SIGNATURE Frank M. Shipley				22b. DATE SIGNED 10/6/60			
22c. PHYSICIAN'S NAME (Type) Frank M. Shipley				22d. ADDRESS 121 Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, or other disposition (Specify) Buried				23b. DATE THEREOF Oct. 3, 1960		23c. NAME OF CEMETERY OR CREMATORY Windy Hill Cem	
23d. LOCATION (City, town, or county) _____ (State) _____				23e. LOCATION (City, town, or county) _____ (State) _____			
24. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newman & Son, Castro Md				25a. REC'D BY REGISTRAR DATE OCT 11 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

988

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00865

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>aa</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> c. LENGTH OF STAY IN 1b <i>10-6-60</i>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>aa</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Annapolis (Rural)</i> d. STREET ADDRESS <i>Lake Shore Drive</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>William</i> Middle <i>Hymon</i> Last <i>Hymon</i>		4. DATE OF DEATH Month <i>Sept</i> Day <i>29</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 24 1894</i>
9. AGE (In years last birthday) <i>66</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machinist</i>	11. BIRTHPLACE (State or foreign country) <i>Poland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>William Hymon</i>	
14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>212-102119</i>		17. INFORMANT <i>Mae Militia Hymon #2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>134.4 Cardiac Arrest</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cardiac Arrest</i> DUE TO (c) <i>Cardiac Arrest</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: (Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>)			
ACTUAL SIGNATURE <i>John M. Taylor</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>John M. Taylor</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REINTERMENT (Specify) <i>Oct 3, 1960 Cedar Bluff Cem.</i>		22b. DATE THEREOF <i>Oct 3, 1960</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Annapolis Md.</i>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i>		24a. REC'D BY REGISTRAR <i>Oct 3 '60</i>	
ADDRESS <i>South Annapolis Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for to burial-cremation or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9913

CERTIFICATE OF DEATH

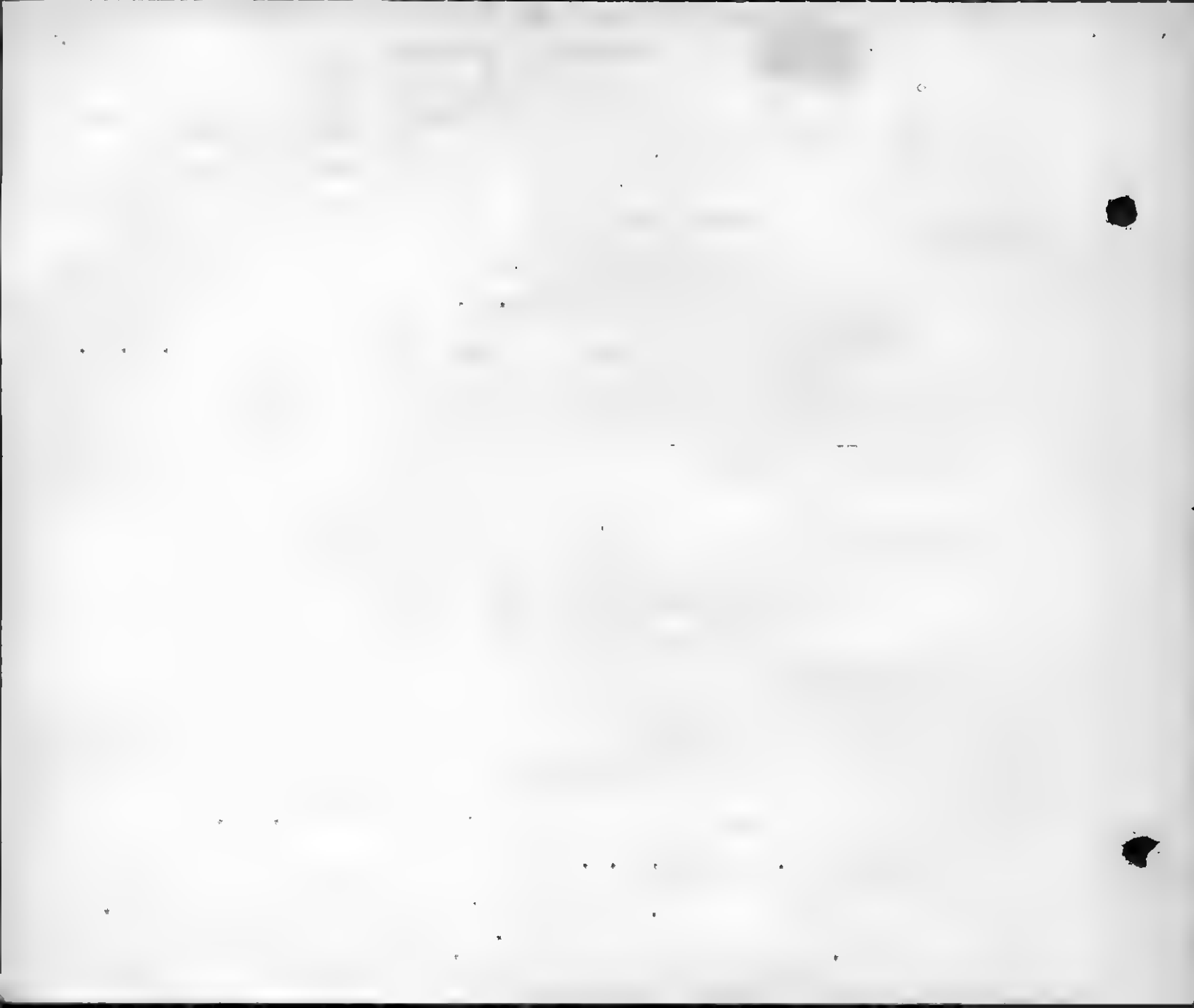
Reg. Dist. No.

09866

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admiss on) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bristol				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pig Point				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MATTIE First Middle Last Cleveland Ireland				4. DATE OF DEATH Month Sept Day 14 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 11, 1883	
9. AGE (in years lost birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME James Brady				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Joseph Albert Ireland-Same as Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 442X IMMEDIATE CAUSE (a) Cerebral Collapse DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Interventricular C.V.R. Murmur DUE TO (c) 10 yrs				INTERVAL BETWEEN ONSET AND DEATH 442X 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Upper Marlboro, Md.				20g. (County) Prince Georges		20h. (State) Md.	
21. I certify that I attended the deceased from June 1950 to Sept 14, 1960 , that I last saw the deceased alive on 14 Sept 1960 , and that death occurred at 10:20 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature]				DATE SIGNED 9/14/60			
PHYSICIAN'S NAME (Type) Robert B. Sasscer, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/17/60		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) (State) Upper Marlboro Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Fun'l Home-Upper Marlboro				24a. REC'D BY REGISTRAR DATE SEP 21 '60		24b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9914

CERTIFICATE OF DEATH

Reg. Dist. No. 09867

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Georges</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Georges</u>	
c. LENGTH OF STAY IN 1b <u>since 7/6/37</u>		d. STREET ADDRESS <u>7700 Prince Georges Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges State</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>AGNES</u> Middle <u>JACKSON</u> Last <u>JACKSON</u>		4. DATE OF DEATH <u>SEPTEMBER 11 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 1-1918</u>
9. AGE (In years last birthday) <u>42</u> yrs.		10. IF UNDER 1 YEAR: Months <u>42</u> Days <u>11</u> Hours <u>19</u> Min. <u>60</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none known</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Mamie Ewins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Hospital records</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY— IMMEDIATE CAUSE (a) <u>pelvic thrombosis and embolism</u> (b) <u>hysterectomy</u> (c) <u>leukopenia - catatonic type</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>since 9/4/60</u> <u>since 9/9/60</u> <u>since 1937</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year <u>19</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>		21. I certify that I attended the deceased from <u>7/6/37</u> , 19 <u>60</u> , to <u>9/4/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>9/4/60</u> , 19 <u>60</u> , and that death occurred at <u>9:20 P.M.</u> from the causes and on the date stated above.	
21a. SIGNATURE <u>Mamie Ewins</u> M.D. <u>Crownsville State Hospital</u>		21b. ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u>	
21c. DATE SIGNED <u>9/12/60</u>		21d. PHYSICIAN'S NAME (Type) <u>L. BENEDICT M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>9-17-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>A.A. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. Harris III</u> ADDRESS <u></u>		24a. REC'D BY REGISTRAR <u></u> 24b. REGISTRAR'S SIGNATURE <u></u>	
DATE <u>SEP 20 '60</u>		<u></u>	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

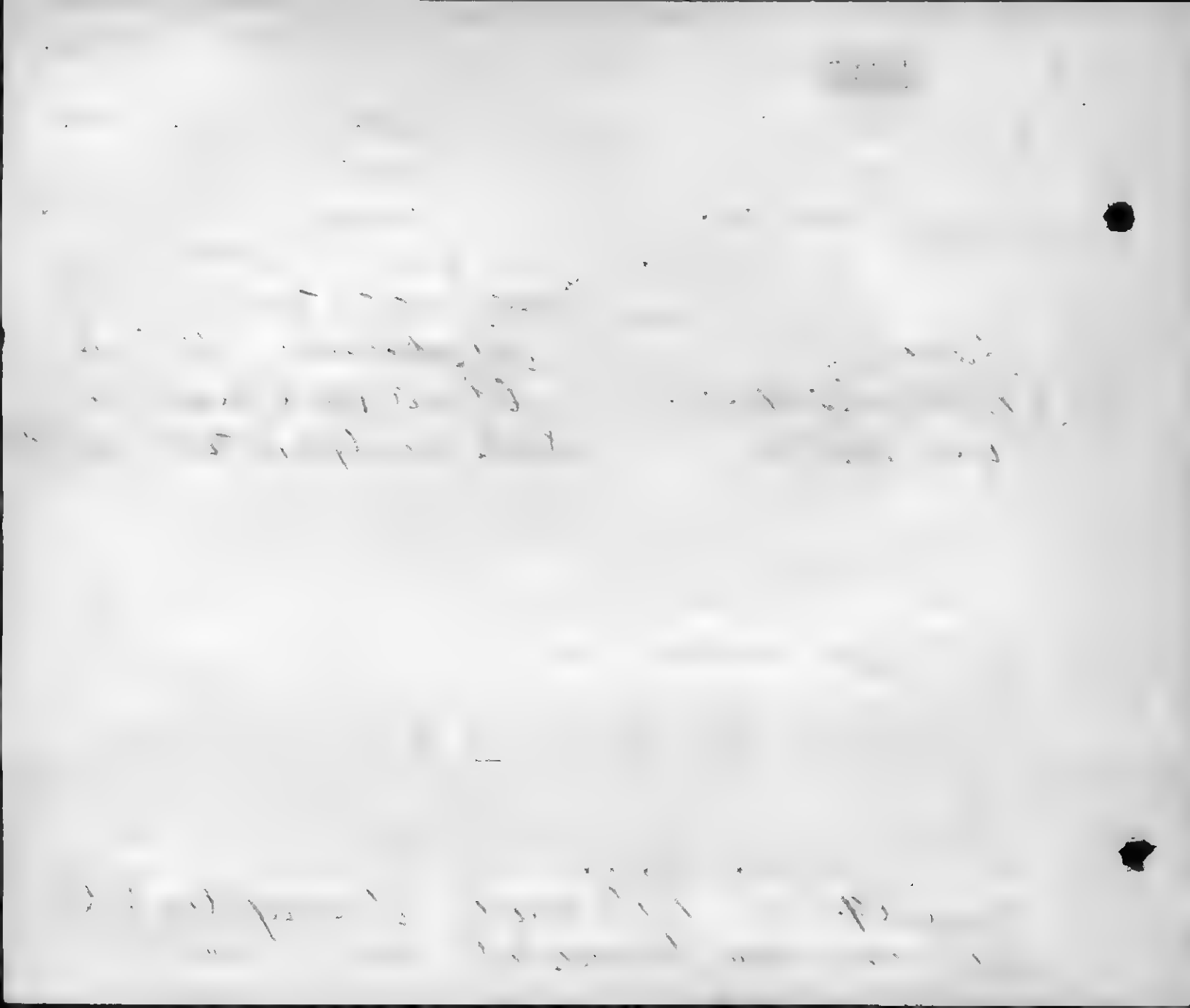
TO DEF. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

Item 18 Film 272 10-11-66 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9915 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 19868

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Parole		c. LENGTH OF STAY in 1b MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rear of Katcefs Tavern.		d. STREET ADDRESS Rina Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) WILLIE B. JACKSON		4. DATE OF DEATH Month September Day 1 Year 19 60	
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-28-1923		9. AGE (In years last birthday) 36 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Willie Jackson	
14. MOTHER'S MAIDEN NAME Edna Beell Leonard		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give branch or dates of service) Yes M.M. 2		16. SOCIAL SECURITY NO.		17. INFORMANT S. S. Leonard P.O. Box 765 Annapolis MD		18. INTERVAL BETWEEN ONSET AND DEATH	
19. CAUSE OF DEATH (Enter only one cause pertinent for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Emaciation due to Chronic Pancreatitis 587.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a, b, or c.									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour 9 a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Annapolis		20g. (County) MD	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/2/60	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-8-1960		22c. NAME OF CEMETERY OR CREMATORY National		22d. LOCATION (City, town, or county) Annapolis MD	
FURNERAL DIRECTOR William Reese		ADDRESS Annapolis MD		24a. REC'D BY REGISTRAR SEP 6 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9882

CERTIFICATE OF DEATH

Reg. Dist. No.

09869

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>"At his home"</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John H. Johns</u>		4. DATE OF DEATH <u>9</u> Month <u>3</u> Day <u>19</u> Year <u>60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 7 1876</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	11. BIRTHPLACE (State or foreign country) <u>Chesterfield A.A. Co</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Thomas Johns</u>	
14. MOTHER'S MAIDEN NAME <u>Martha Johns</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>214-05-0207</u>		17. INFORMANT <u>Hattie Sorrell</u> Address <u>Annapolis</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Deep Venous Thrombosis</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8-1-60</u> to <u>9-3-60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>9-1-60</u> , 19 <u>60</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>C. C. Cochran</u>		DATE SIGNED <u>9-6-60</u>	
PHYSICIAN'S NAME (Type) <u>A. T. Allen</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept 7/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cent Tabot</u>	22d. LOCATION (City, town, or county) (State) <u>Chesterfield A.A. Co Ind</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Annal A. Johnson</u> ADDRESS <u>Annapolis</u>		24a. REC'D BY REGISTRAR <u>SEP 7 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9916

CERTIFICATE OF DEATH

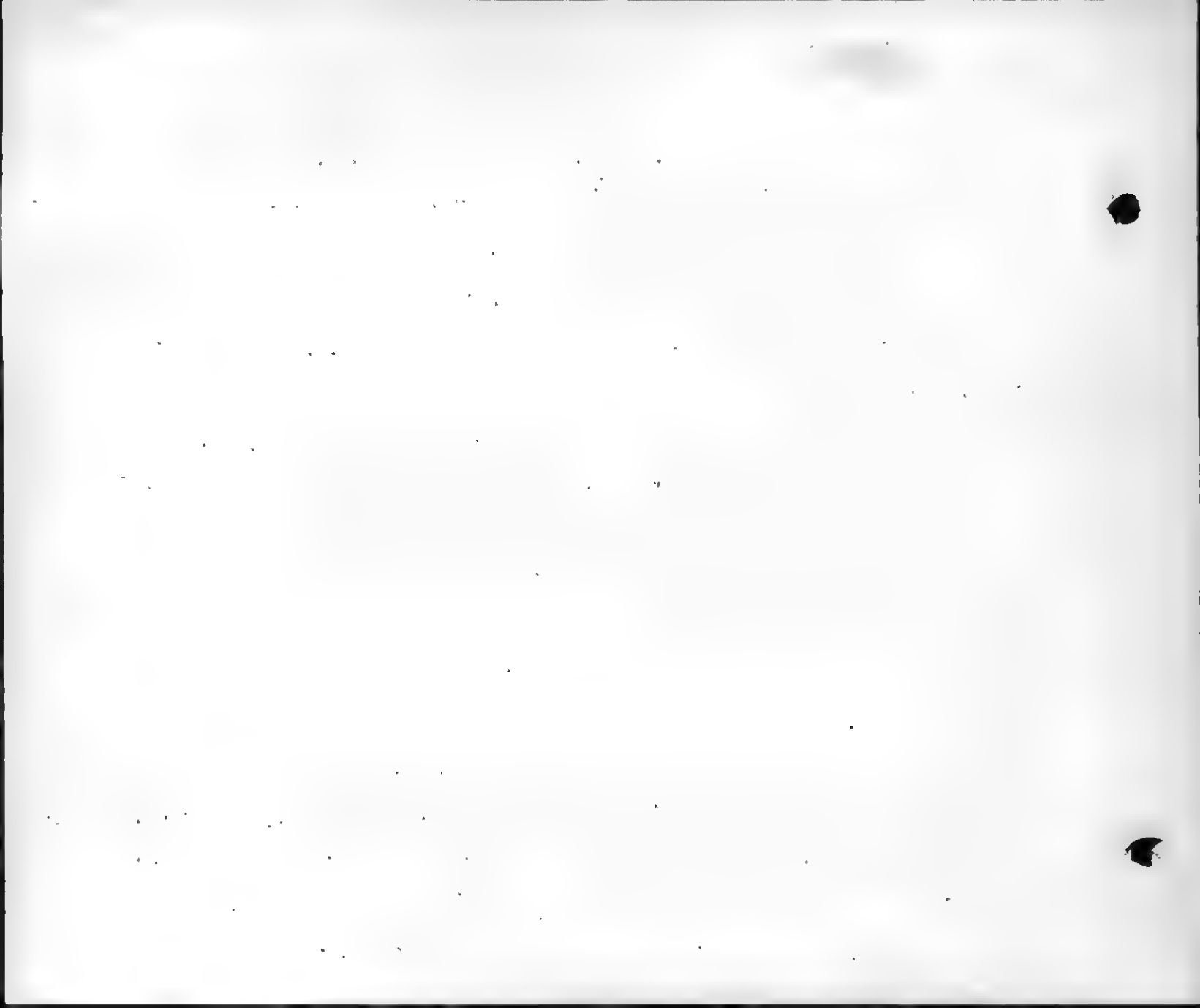
Reg. Dist. No.

09870

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>4-7X</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. LENGTH OF STAY IN 1b <u>2 yr. 3 mos.</u>	
d. NAME OF HOSPITAL OR INSTITUTION <u>Children's Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elestine</u> Middle <u>Cornelia</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>September</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 9, 1941</u>
9. AGE (In years lost birthday) <u>19</u> yrs		10. IF UNDER 1 YEAR: Months <u>19</u> Days <u>15</u> Hours <u>10</u> Min <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Institutionalized</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Newell Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Alice Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Children's Center, Laurel, Md.</u>		Address <u>---</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia - aspiration</u> DUE TO <u>521X</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last (b) <u>Possible lung abscess</u> (c) <u>Convulsive disorder</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5/17/60</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Spastic quadriplegia - mental retardation severe</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>---</u> p. m. <u>---</u> 19 <u>---</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>		20f. (City or town) <u>---</u> (County) <u>---</u> (State) <u>---</u>	
21. I certify that I attended the deceased from <u>6/6/1958</u> to <u>9/15/1960</u> , that I last saw the deceased alive on <u>September 15, 1960</u> , and that death occurred at <u>3:10 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James E. Boyland</u> M.D.		ADDRESS (Street, city or town, state) <u>Children's Center, Laurel, Md.</u> DATE SIGNED <u>9/15/60</u>	
PHYSICIAN'S NAME (Type) <u>James E. Boyland, M.D.</u>		Children's Center, Laurel, Md. 9/15/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>9/20/60</u>		22b. DATE THEREOF <u>9/20/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		22d. LOCATION (City, town, or county) <u>Md.</u> (State) <u>---</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hoffman's Funeral</u> ADDRESS <u>909-6 St NW</u>		24a. REC'D BY REGISTRAR <u>---</u> DATE <u>9/17/60</u>	
24b. REGISTRAR'S SIGNATURE <u>---</u>		25. <u>---</u>	

SEP 19 1960

Arthur S. Hunt



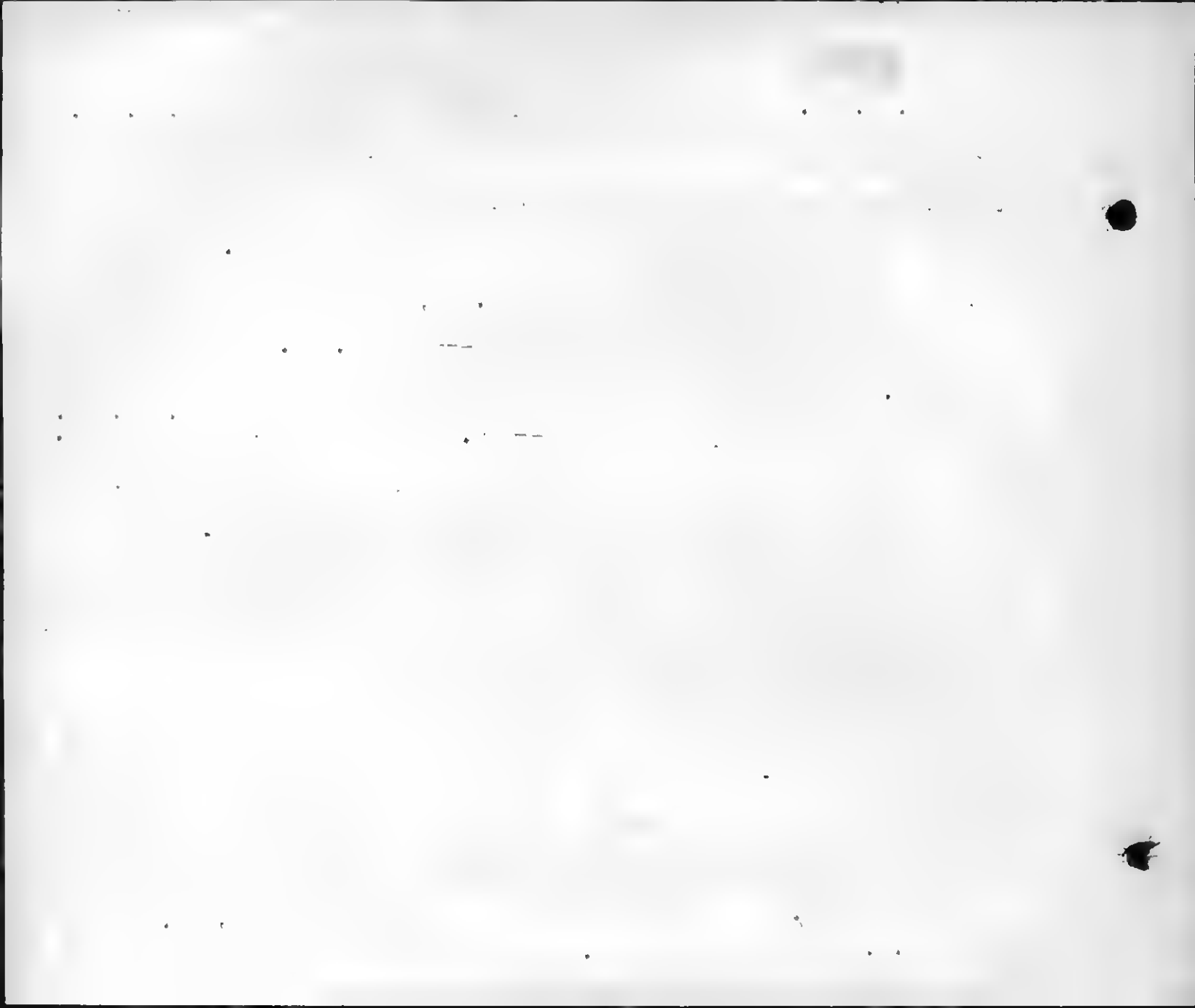
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9917

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09871

1 PLACE OF DEATH a. COUNTY A. A. Co. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Linthicum		2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY A. A. CO. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Linthicum	
d. NAME OF HOSPITAL (If not in hospital, give street address) 109 Charles Road		d. STREET ADDRESS 109 Charles Road	
3. NAME OF DECEASED (Type or print) Edgar Ray Joyce		4. DATE OF DEATH Month Sept. Day 7 Year 1960	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 25, 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Painter		10b. KIND OF BUSINESS OR INDUSTRY Keating Contractor---	11. BIRTHPLACE (State or foreign country) Balto. Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME late Wm. Joyce	
14. MOTHER'S MAIDEN NAME Martha Ellen		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes	
16. SOCIAL SECURITY NO. WW 1 218 01 2338		17. INFORMANT A -- Mrs. Delmar Joyce, 109 Charles Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Failure (Cor Pulmonale) DUE TO (b) Chronic Hypertrophic Emphysema DUE TO (c) 7 yrs		INTERVAL BETWEEN ONSET AND DEATH 3 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (his hospital) attended the deceased from Aug 8, 1960 to Sept 7, 1960 that (I) (we) last saw the deceased alive on Sept 3, 1960 , and that death occurred at 1:30 PM , from the causes and on the date stated above.	
22a. SIGNATURE C. Arthur Rossberg		22b. DATE SIGNED 9/7/60	
22c. PHYSICIAN'S NAME (Type) C. ARTHUR ROSSBERG		22d. ADDRESS 2436 Washington Blvd - 30	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/10/60	23c. NAME OF CEMETERY OR CREMATORY Loudon Park	23d. LOCATION (City, town, or county) (State) Baltimore 29, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D.		25a. REC'D BY REGISTRAR SEP 8 '60	
ADDRESS 4101 Edmondson Ave.		25b. REGISTRAR'S SIGNATURE Charles L. Hume	



may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

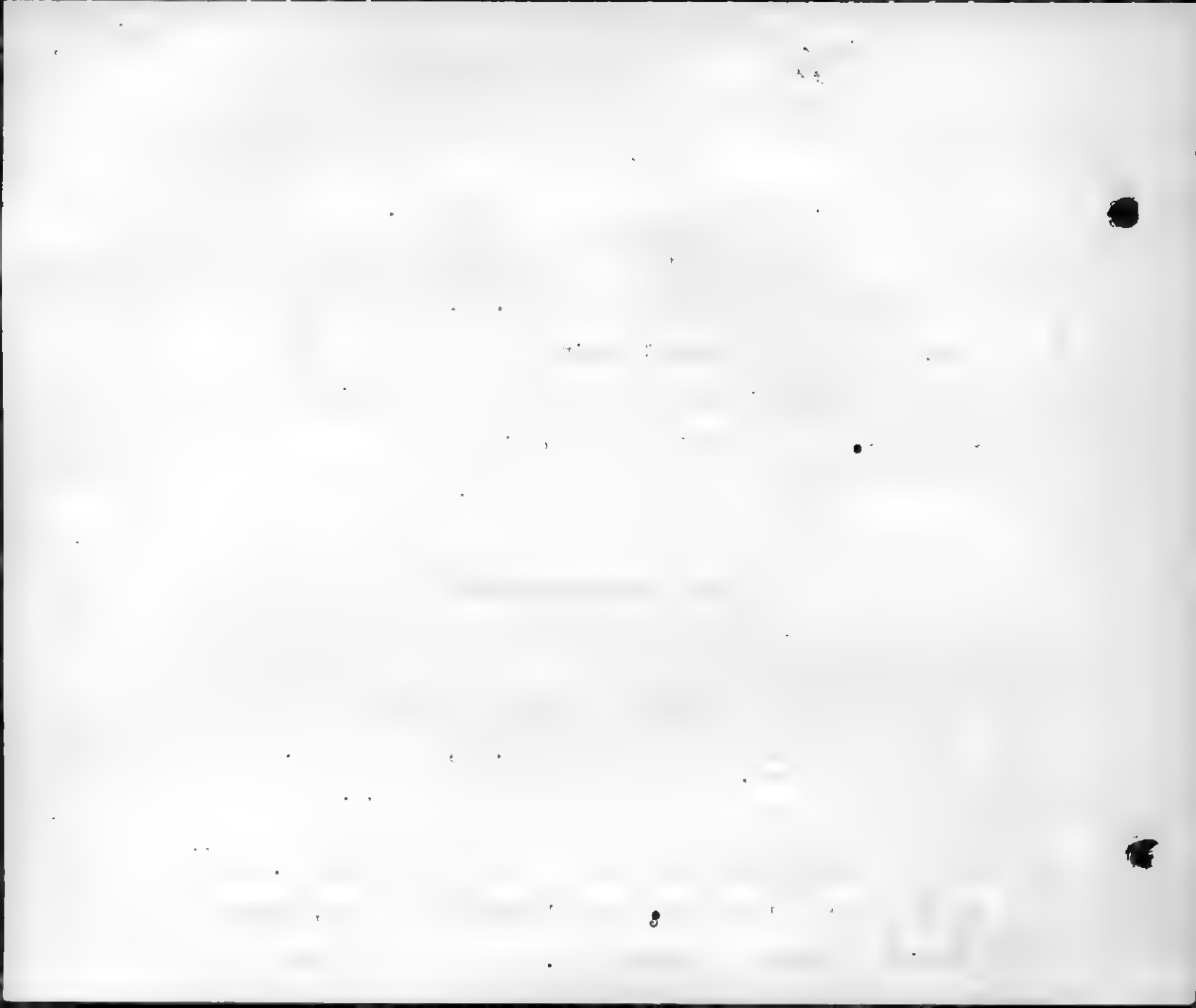
9883

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09872

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Edgewater			
f. STREET ADDRESS Mayo Rd.				g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Henry Middle Peter Last KLINKEN				4. DATE OF DEATH Month September Day 26 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 30, 1892	
9. AGE (n years last birthday) 68 yrs		10. IF UNDER 1 YEAR Months 68 Days 68 Hours 68 Min.		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? US	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Prop.				10b. KIND OF BUSINESS OR INDUSTRY General Hauling			
13. FATHER'S NAME Johan Klinken				14. MOTHER'S MAIDEN NAME Margaret Cummins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 279 14 0766		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) emphysema 1t. chest c pericarditis DUE TO (b) bronchopneumonia (1t. 1.) DUE TO (c) chronic bronchial asthma				INTERVAL BETWEEN ONSET AND DEATH 2 wks 2 wks.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) chronic bronchial asthma				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) thoroughly attended the deceased from Sept. 23, 1960 to Sept. 25, 1960 that (I) was last saw the deceased alive on Sept. 25, 1960 , and that death occurred at 9:27 A.M. M, from the causes and on the date stated above.							
22a. SIGNATURE Samuel Borssuck				22b. DATE SIGNED 9/26/60			
22c. PHYSICIAN'S NAME (Type) Samuel Borssuck				22d. ADDRESS Amos Garrett Blvd., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 29, 1960		23c. NAME OF CEMETERY OR CREMATORY Mayo Memorial Cemetery		23d. LOCATION (City, town, or county) (State) Mayo, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				25a. REC'D BY REGISTRAR DATE SEP 30 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

MEDICAL CERTIFICATION



9918

CERTIFICATE OF DEATH

Reg. Dist. No.

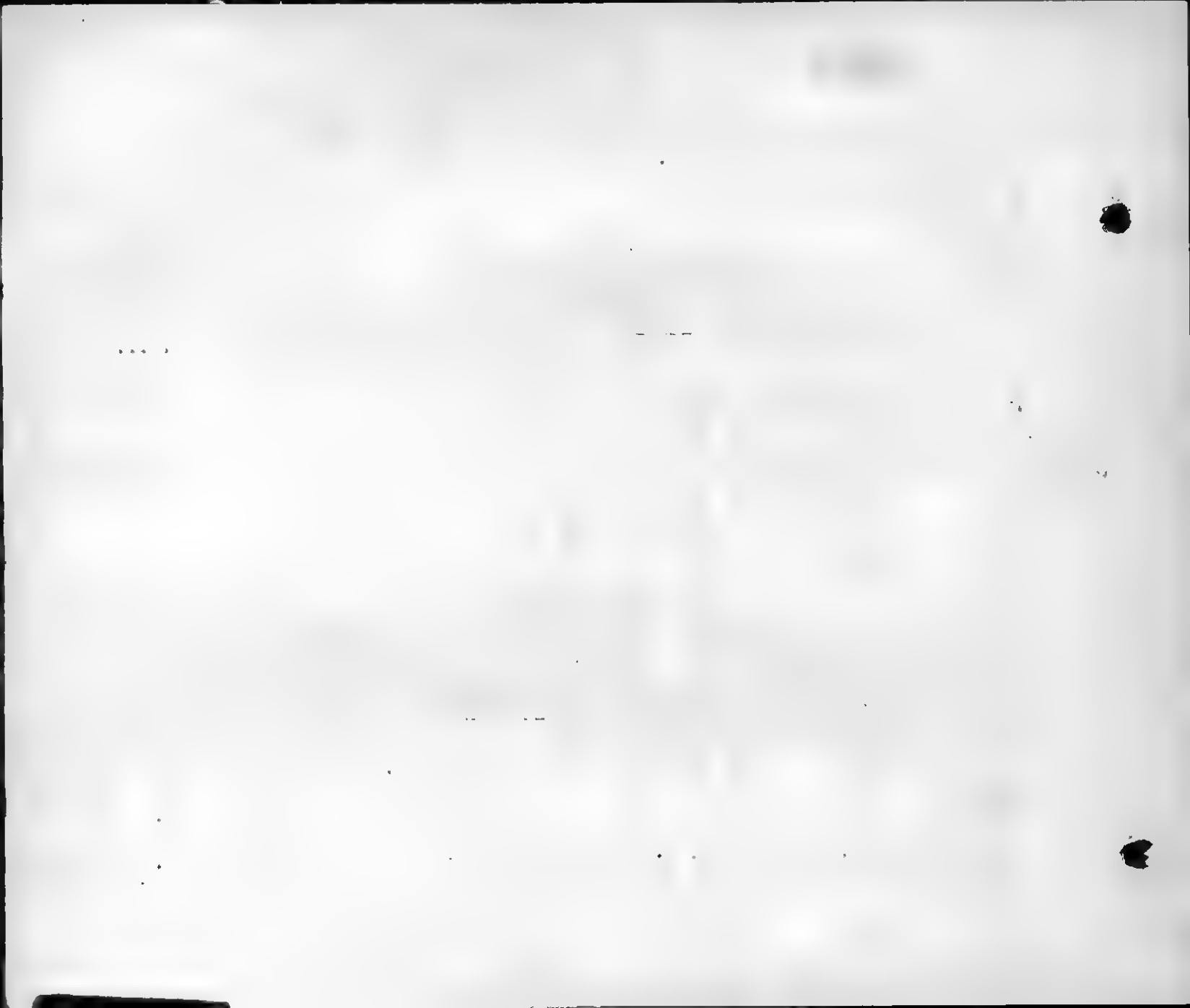
1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 6mo. 6 years 10 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) d. STATE Maryland		e. COUNTY Baltimore City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. STREET ADDRESS 2306 Bryant Avenue				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Frank		Middle Jerome		Last Lee		4. DATE OF DEATH Month 9 Day 25 Year 1960	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1878		9. AGE (In years last birthday) 82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Hospital Records					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Edema + Terminal Bronchopneumonia		
DUE TO (b) Subdural Hemorrhage		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour 19 a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/6 , 19 50 , to 9/25 , 19 60 , that I last saw the deceased alive on 9/25 , 19 60 , and that death occurred at 12:25 A.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)						DATE SIGNED	
ACTUAL SIGNATURE L. Benedict, M. D.				M. D. Crownsville State Hospital, Md. 9/26/60			
PHYSICIAN'S NAME (Type)				M. D. Crownsville State Hospital, Md. 9/26/60			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 9-29-60		22c. NAME OF CEMETERY OR CREMATORY W. H. Jackson		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Jackson				24a. REC'D BY REGISTRAR DATE SEP 29 '60		24b. REGISTRAR'S SIGNATURE W. H. Jackson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 48 hours after death.



CERTIFICATE OF DEATH

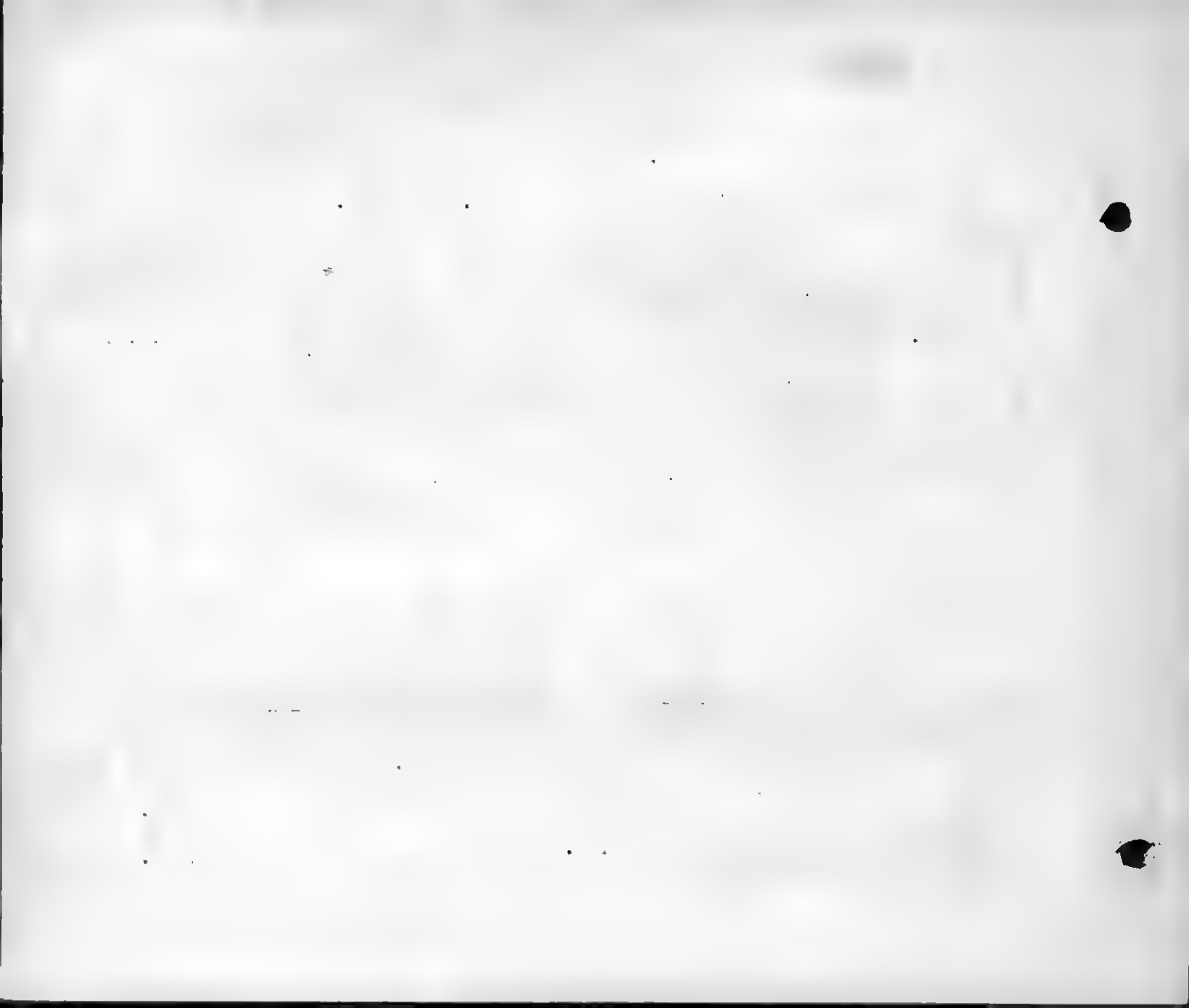
Reg. Dist. No.

9919

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY in 1b 2 years 7mo. 24 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 27 S. Duncan St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last James Westly Lee		4. DATE OF DEATH Month Day Year 9 9 19 60	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 28, 1865
9. AGE (In years lost birthday) 95 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Lee		14. MOTHER'S MAIDEN NAME Susie Brown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia and Dehydration 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic Cardiovascular Renal Disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome Associated with Arteriosclerosis and Senility; Bronchogenic Carcinoma			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) -----	
20c. TIME OF INJURY Month, Day, Year Hour a. m. --- p. m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from 1/15 , 19 58 to 9/9 , 19 60 , that I last saw the deceased alive on 9/9 , 19 60 , and that death occurred at 8:30A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Crownsville State Hospital, Md. 9/9/60			
ACTUAL SIGNATURE Lionel McHenry Mapp, M. D.		PHYSICIAN'S NAME (Type) Crownsville State Hospital, Md. 9/9/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) 9-16-60		22b. DATE THEREOF University of Md. Balto. Md.	
22c. NAME OF CEMETERY OR CREMATORY University of Md. Balto. Md.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese II		ADDRESS Annapolis Md.	
24a. REC'D BY REGISTRAR DATE SEP 16 '60		24b. REGISTRAR'S SIGNATURE William A. Knecht	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



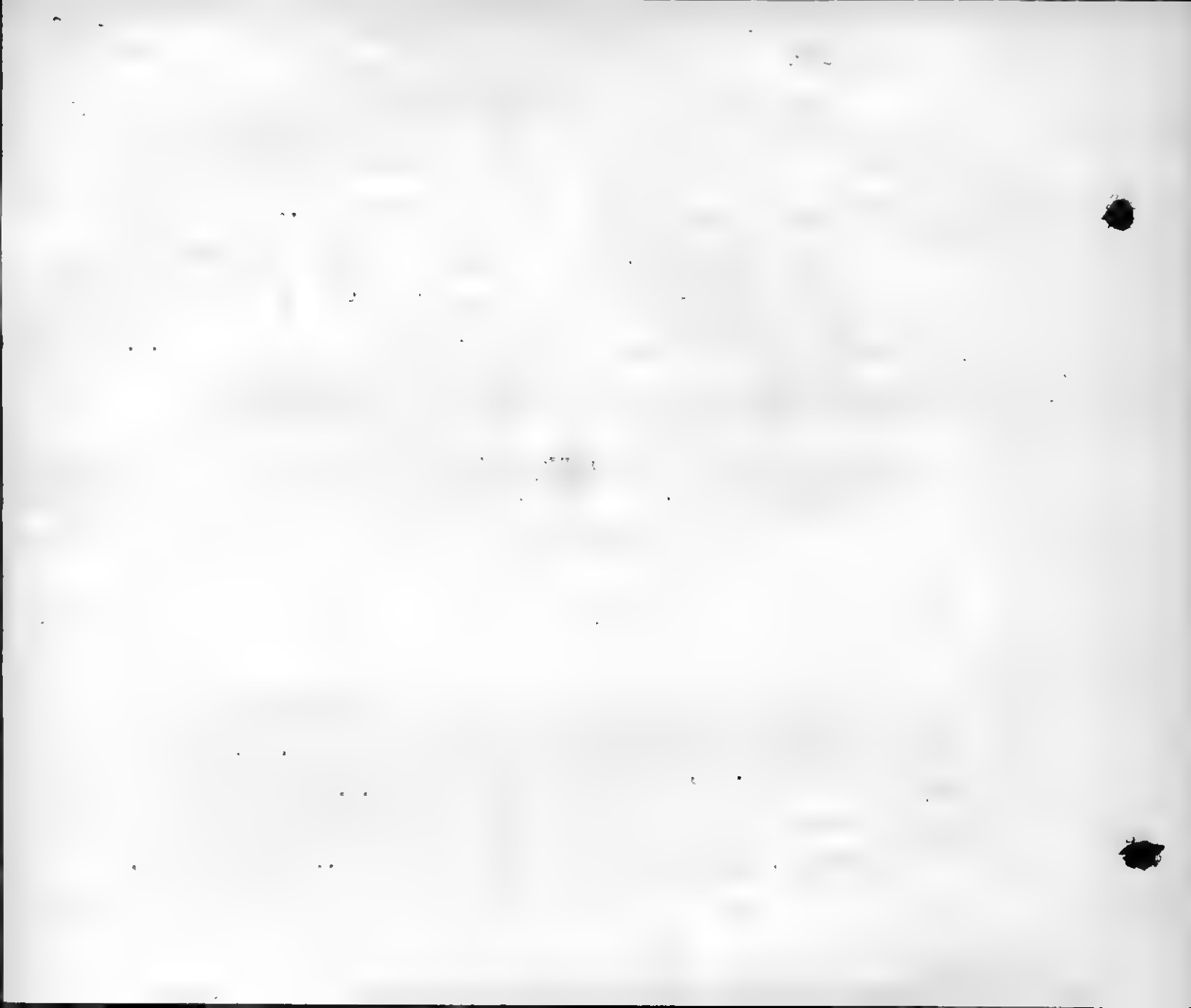
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director should be filled with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

9884

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09875

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institut on Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne A. undel General Hospital		d. STREET ADDRESS 310 Severn Ave.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle ANN Last LEWIS		4. DATE OF DEATH Month September Day 17 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 27, 1888
9. AGE (In years lost birthday) 77 yrs		10. IF UNDER 1 YEAR Months 7 Days 7 Hours 7 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Edward Brown		14. MOTHER'S MAIDEN NAME Mary Ann Lunning	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 1	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 48 HOURS 10 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) physician attended the deceased from 9-15-1960 to Sept. 17, 1960 , that (I) last saw the deceased alive on Sept. 17, 1960 , and that death occurred at 7:30 P.M. M, from the causes and on the date stated above.			
22a. SIGNATURE Edward S. Beck M.D.		22b. DATE 9/19/60	
22c. PHYSICIAN'S NAME (Type) Edward S. Beck		22d. ADDRESS 71 Franklin St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-26-1960	
23c. NAME OF CEMETERY OR CREMATORY St. Ann's Cemt		23d. LOCATION (City, town, or county) (State) Annapolis Md	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Inc		25a. REC'D BY REGISTRAR DATE SEP 21 '60	
25b. REGISTRAR'S SIGNATURE Charles L. Hume			



CERTIFICATE OF DEATH

Reg. Dist. No.

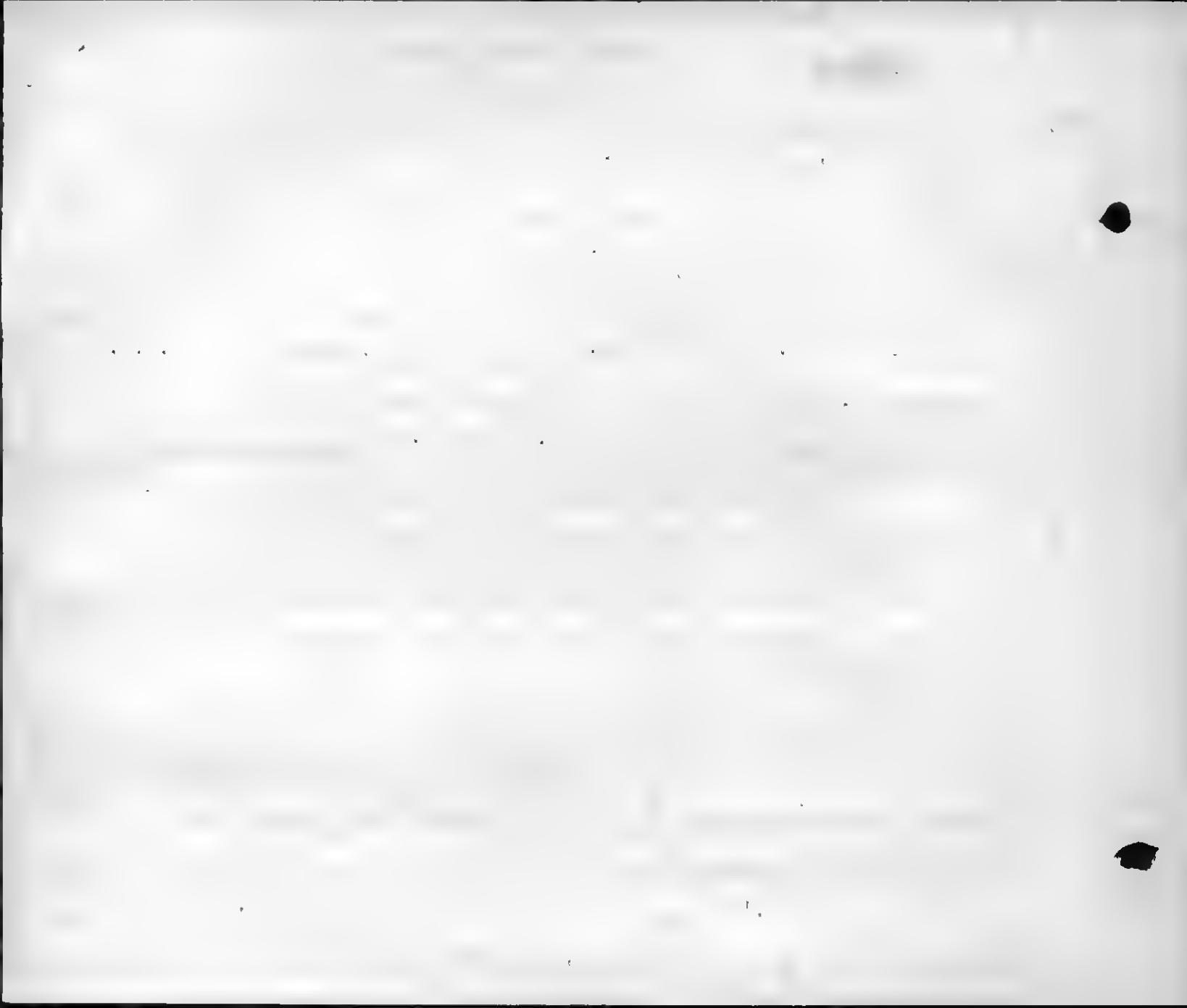
9920

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie,				c. LENGTH OF STAY IN TB 2 mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION #401 Phelps Avenue				d. STREET ADDRESS #401 Phelps Avenue			
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MARIVERNIS Middle (MARY V.) Last LLOYD				4. DATE OF DEATH Month SEPT Day 21 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4 March 1910	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary (ret.) Limestone Co.				10b. KIND OF BUSINESS OR INDUSTRY Olive Hill		11. BIRTHPLACE (State or foreign country) Olive Hill, Kentucky	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Ormand L. Kerns				14. MOTHER'S MAIDEN NAME Anna Rucker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		(If yes, give war or dates of service) //////////		16. SOCIAL SECURITY NO. 403 01 0577		17. INFORMANT Mr. Thomas W. Lloyd	
Address Same As #2							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED CARCINOMATOSIS 2000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) RETICULUM CELL SARCOMA DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS 1 1/2 YRS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CACHEXIA							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from JAN. 1956 to SEPT. 21, 1960 , that I last saw the deceased alive on SEPT. 20, 1960 , and that death occurred at 12:42 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2934 MOUNTAIN RD. PASADENA, MARYLAND DATE SIGNED 9-21-60 ACTUAL SIGNATURE Arthur Lankford Jr. M.D. PHYSICIAN'S NAME (Type) ARTHUR LANKFORD JR. PASADENA, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 24th Sept. '60		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		22d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE R. V. Singleton				ADDRESS Glen Burnie, Maryland		24a. REC'D BY REGISTRAR SEP 26 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kerns			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 FOR STATE HEALTH DEPT.

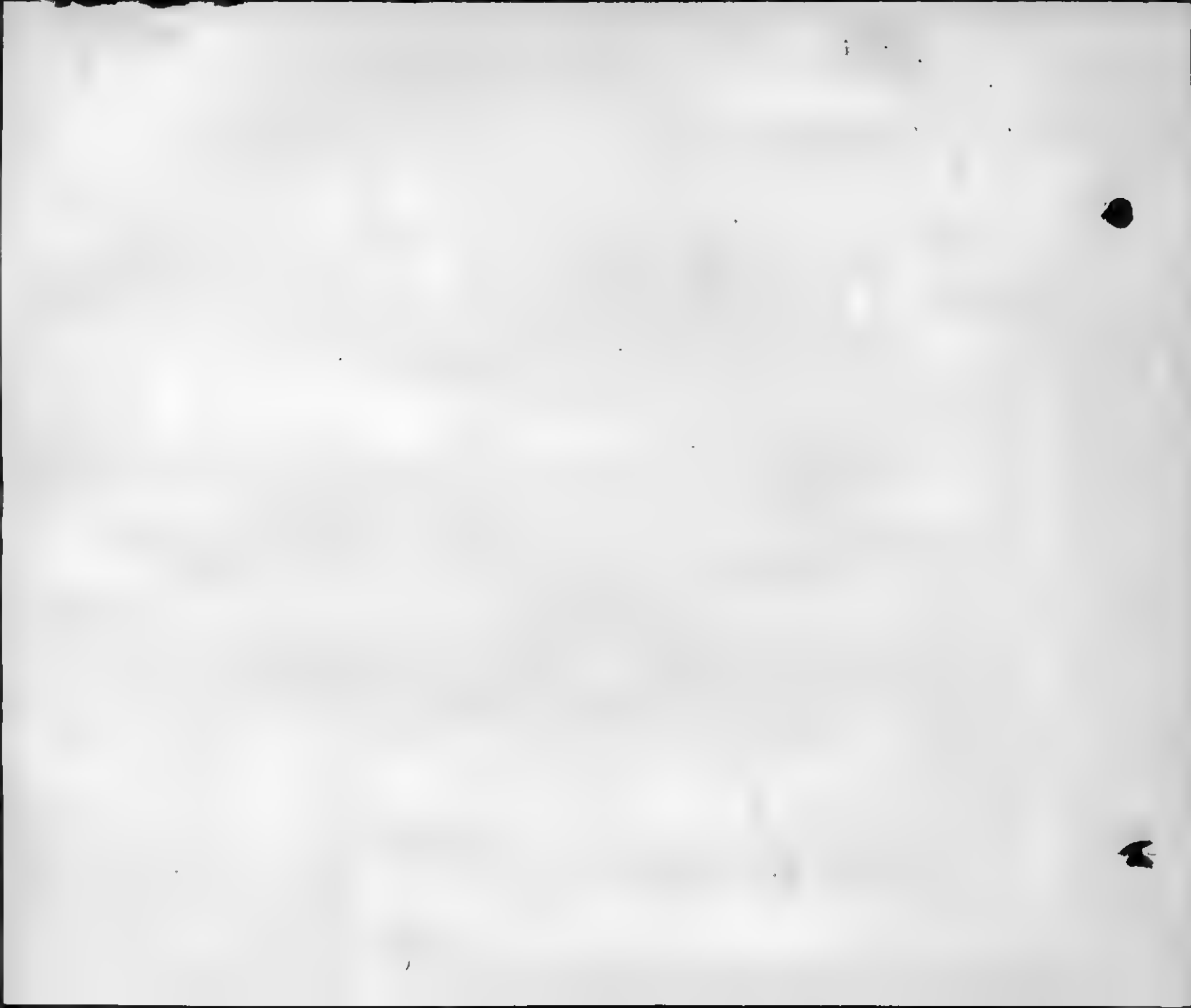
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH 9921 STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena c. LENGTH OF STAY IN TB 20 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Box 209 Thick Neck Road.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Same b. COUNTY Same c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same d. STREET ADDRESS Same		3. NAME OF DECEASED (Type or print) Albert Charles Long		4. DATE OF DEATH September 5th 19 60	
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/19/86/ 1895	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired truck driver		10b. KIND OF BUSINESS OR INDUSTRY for Baltimore News		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Long				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) First World War.		16. SOCIAL SECURITY NO. 212-03-0416		17. INFORMANT Mrs. Anna Long (wife)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Custace H. Faubert, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Custace H. Faubert, M.D.		DATE SIGNED 9/5/60		Address (Street, city, town, or county) Glen Burnie, Md.		(State)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-8-60		22c. NAME OF CEMETERY OR CREMATORY Holy Cross		22d. LOCATION (City, town, or county) Baltimore	
23. FUNERAL DIRECTOR McCluskey, 130 E. Fort Ave				24a. REC'D BY REGISTRAR SEP 8 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

MEDICAL CERTIFICATION

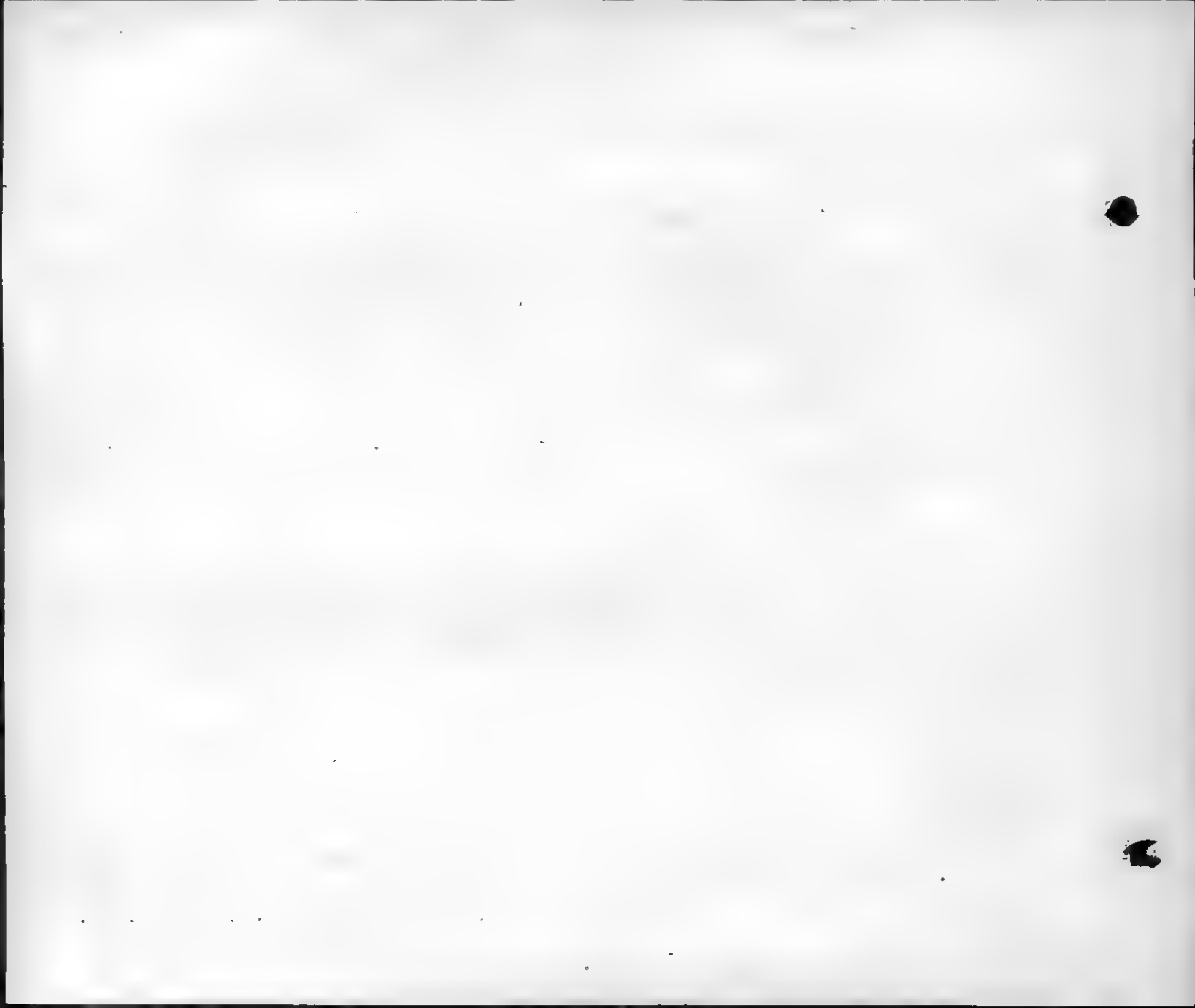


9885

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09878

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN TB			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				e. STREET ADDRESS <u>Machovsky Ave.</u>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>MACHOVSKY</u> Last				4. DATE OF DEATH Month <u>Sept</u> Day <u>1</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Sept 19, 1903</u>	
9. AGE (In years last birthday) <u>56</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate Investor</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Martin Machovsky</u>				14. MOTHER'S MAIDEN NAME <u>Anna Kobsky</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>		17. INFORMANT <u>Robert Rank - Adm. of Estate</u> Address <u>107 Severn Dr. v. 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ac. Pulmonary Edema</u> 522X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last (b) <u>Maemia</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>old st. Hemiplegia</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1, 1960</u> to <u>Sept 3, 1960</u> , that (I) (we) last saw the deceased alive on <u>Sept 3, 1960</u> , and that death occurred at <u>35</u> M. from the causes and on the date stated above							
22a. SIGNATURE <u>Maurice Klavans</u> M.D.				22b. ADDRESS <u>31 Southgate Dr. Annapolis, Md.</u>		22c. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept 6, 60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Weems Creek Cmt.</u>		23d. LOCATION (City, town, or county) (State) <u>Weems Creek, Annapolis, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u> ADDRESS <u>Annapolis, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 6 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled out by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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9886

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09879

1 PLACE OF DEATH a. COUNTY <i>A. A.</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission) a. STATE <i>Maryland</i> COUNTY <i>A. A.</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> c. STREET ADDRESS <i>8 Nabel Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Emma Mason</i>		4. DATE OF DEATH Month Day Year <i>9 1 1960</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-20-1879</i>	9. AGE (In years last birthday) <i>80</i> yrs	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Frank Carroll</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Carroll</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Pearl Carroll 8 Nabel Ave</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Interosclerotic Hypertensive cardio</i> DUE TO <i>vascular disease grade III</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	
20f. (City or town) <i>Annapolis</i>		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Sept 1, 1960</i> to <i>Sept 1, 1960</i> , that (I) (we) last saw the deceased alive on <i>Sept 1, 1960</i> , and that death occurred at <i>11</i> M, from the causes and on the date stated above.					
22a. SIGNATURE <i>R. L. Richardson</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>R. L. Richardson, M.D.</i>		22d. ADDRESS <i>110 Clay Street</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>9-5-60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Our Lady of the Field</i>	
23d. LOCATION (City, town, or county) <i>Annapolis, Maryland</i>		(State) <i>A.A.</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE <i>SEP 6 '60</i>	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kress</i>	

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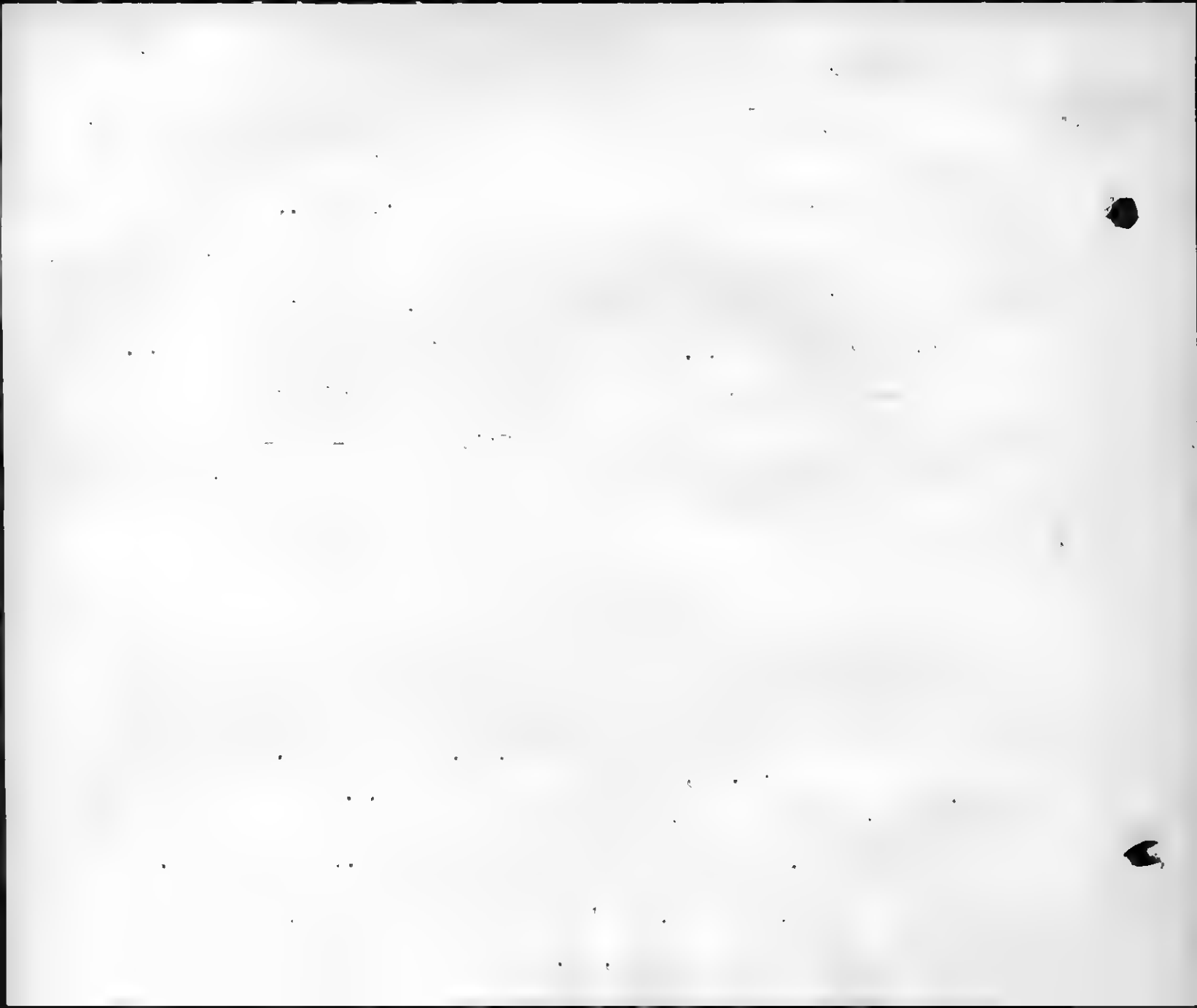
may be signed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
 9887
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

09880

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION AnneArundel General Hospital		d. STREET ADDRESS 61 Amos Garrett Blvd.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle C Last McGUCKIAN		4. DATE OF DEATH Month September Day 20 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 28, 1890
9. AGE (In years last birthday) 69 yrs		IF UNDER 1 YEAR: Months 69 Days 69 Hours 69 Min 69	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Veteran		10b. KIND OF BUSINESS OR INDUSTRY U.S. Army	
11. BIRTHPLACE (State or foreign country) Maine		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas McGuckian		14. MOTHER'S MAIDEN NAME Margaret Greirson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO none	
17. INFORMANT Mrs Elsie McGuckian- Wife- same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO ARTERIOSCLEROTIC HEART DISEASE CONGESTIVE FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 DAY DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CEREBRAL ARTERIOSCLEROSIS 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) the deceased attended the deceased from Sept. 18, 1960 to Sept. 20, 1960 , that (I) did last saw the deceased alive on Sept. 20, 1960 , and that death occurred at 9:35 P.M. M, from the causes and on the date stated above.			
22a. SIGNATURE Edward S. Beck		22b. DATE SIGNED 9/21/60	
22c. PHYSICIAN'S NAME (Type) Edward S. Beck		22d. ADDRESS 71 Franklin St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept 23, 1960	23c. NAME OF CEMETERY OR CREMATORY St. Anne's Cemetery	23d. LOCATION (City, town, or county) (State) Annapolis, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		25a. REC'D BY REGISTRAR SEP 26 '60	
ADDRESS Annapolis, Md.		25b. REGISTRAR'S SIGNATURE C. L. S. H. H.	

MEDICAL CERTIFICATION



may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

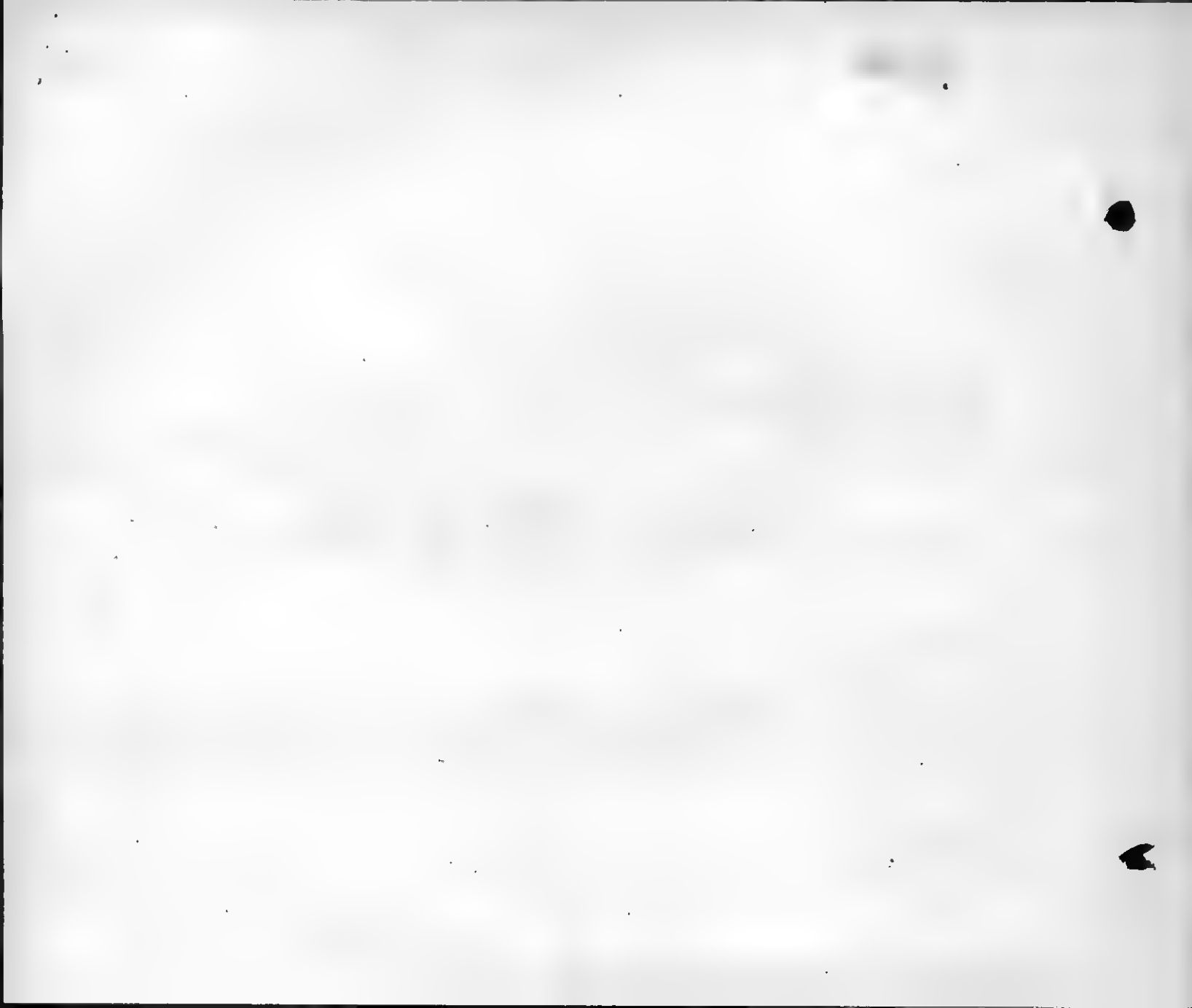
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9922

CERTIFICATE OF DEATH

09881

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>A.A.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Co</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Northwood Manor N. H.</u>		d. STREET ADDRESS <u>1112 Furber Dr.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Cebras</u>		4. DATE OF DEATH <u>Sept 16, 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>25 May 1869</u>
9. AGE (In years, lost birthday) <u>90</u> yrs		10. IF UNDER 1 YEAR: Months <u>9</u> Days <u>16</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Latham</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Ruth M Goedeke</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Vascular Disease</u> 352X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> DUE TO <u>Spontaneous</u> (c) <u>Spontaneous</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Comp Fracture Right Leg</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>Sept 19, 1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Glen Burnie</u> (County) <u>Baltimore</u> (State) <u>Md.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>2/8/60</u> to <u>9/16/60</u> that (I) (we) last saw the deceased alive on <u>9/17/60</u> and that death occurred at <u>3:15 A.M.</u> from the causes and on the date stated above			
22a. SIGNATURE <u>R. D. Singleton</u>		22b. DATE SIGNED <u>9/16/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. D. Singleton</u>		22d. ADDRESS <u>Glen Burnie, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>20th Sept. 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore, Md.</u>		23d. LOCATION (City, town, or county) <u>Baltimore, Md.</u> (State) <u>Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. D. Singleton</u>		25a. REQUIRED BY REGISTRAR <u>SEP 22 1960</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Funes</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

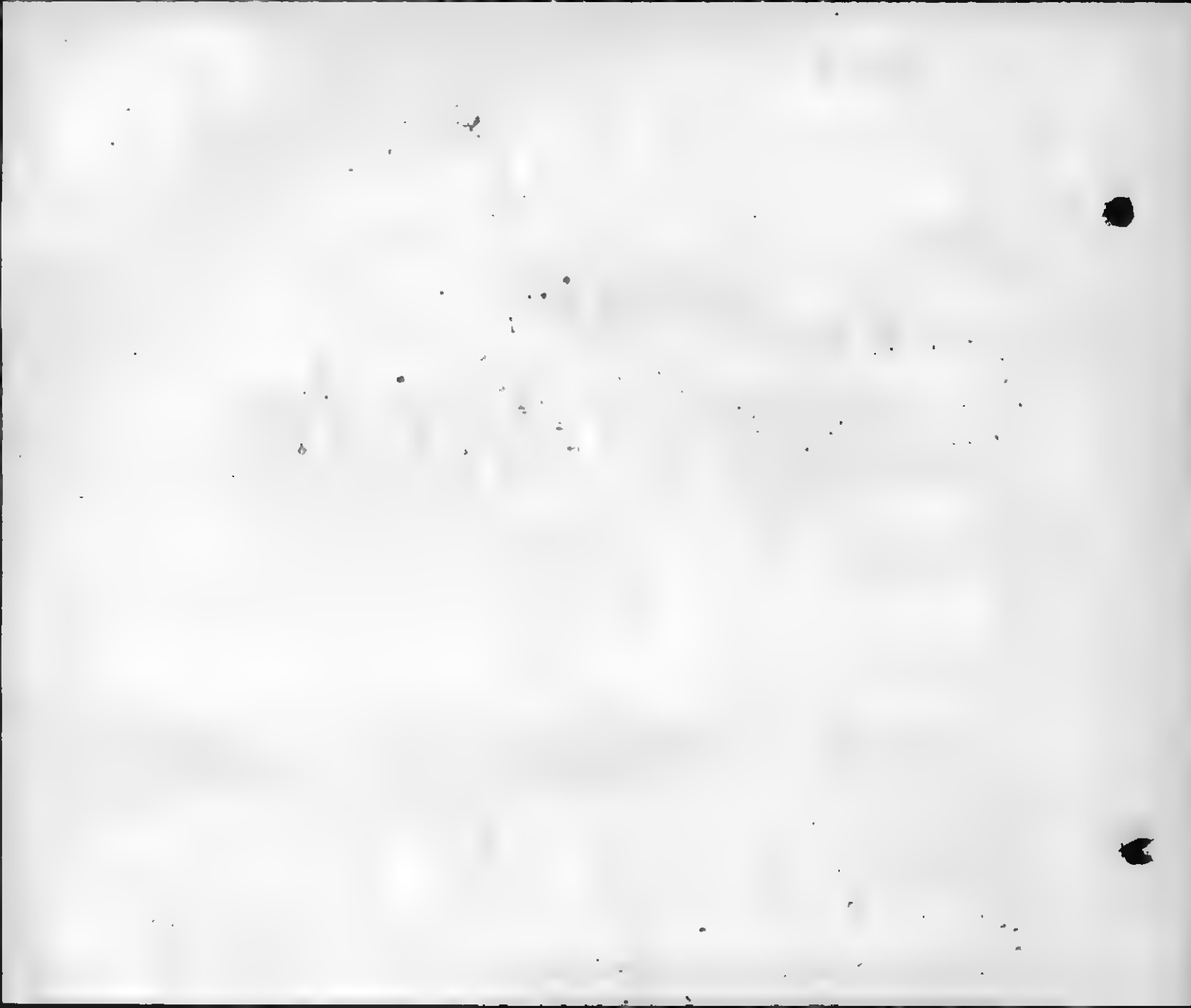
Reg. Dist. No.

09882

9888

1. PLACE OF DEATH a. COUNTY <i>A.A. Co - Cars Beach MARYLAND</i>		2. USUAL RESIDENCE (Where deceased lived. If Institution, residence before admission) ✓ a. STATE <i>Pennsylvania</i> b. COUNTY <i>Philadelphia</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis - RURAL</i>		c. LENGTH OF STAY IN 1b <i>Philadelphia 7-1</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>D.O.M. - Anne Arundel General</i>		d. STREET ADDRESS <i>7818 Laycock Ave.</i>	
3. NAME OF DECEASED (Type or print) First <i>Charles</i> Middle <i>Mitchell</i> Last <i>9</i>		DATE OF DEATH Month <i>9</i> Day <i>4</i> Year <i>1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-7-1928</i>
9. AGE (in years last birthday) <i>31</i> yrs.		IF UNDER 1 YEAR Months <i>31</i> Days <i>4</i> Hours <i>19</i> Min. <i>60</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bar Tender</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Jessy City, N.J.</i>	
11. FATHER'S NAME <i>Douglas Mitchell</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. MOTHER'S MAIDEN NAME <i>Beverly Scott</i>		14. INFORMANT <i>Douglas Mitchell 7818 Laycock Ave. Phila. Pa.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes Army</i>		16. SOCIAL SECURITY NO. <i>7818 Laycock Ave. Phila. Pa.</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>729.8 Drowning</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Sudden</i> (c) <i>Sudden</i> DUE TO cause last.		18. INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>While swimming at Sparrows Beach</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>9-4-60</i> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <i>Beach</i>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Beach</i>		20f. (City or town) (County) (State) <i>A.A. Co MD</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. Linhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. Linhardt</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 9-12-60</i>		22b. DATE THEREOF <i>9-12-60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Beverly Natl.</i>		22d. LOCATION (City, town, or county) (State) <i>Beverly, N.J.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Seese, Jr. - Annapolis, Md.</i>		24a. REC'D BY REGISTRAR <i>DATE SEP 8 '60</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Evans</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.



CERTIFICATE OF DEATH

09883

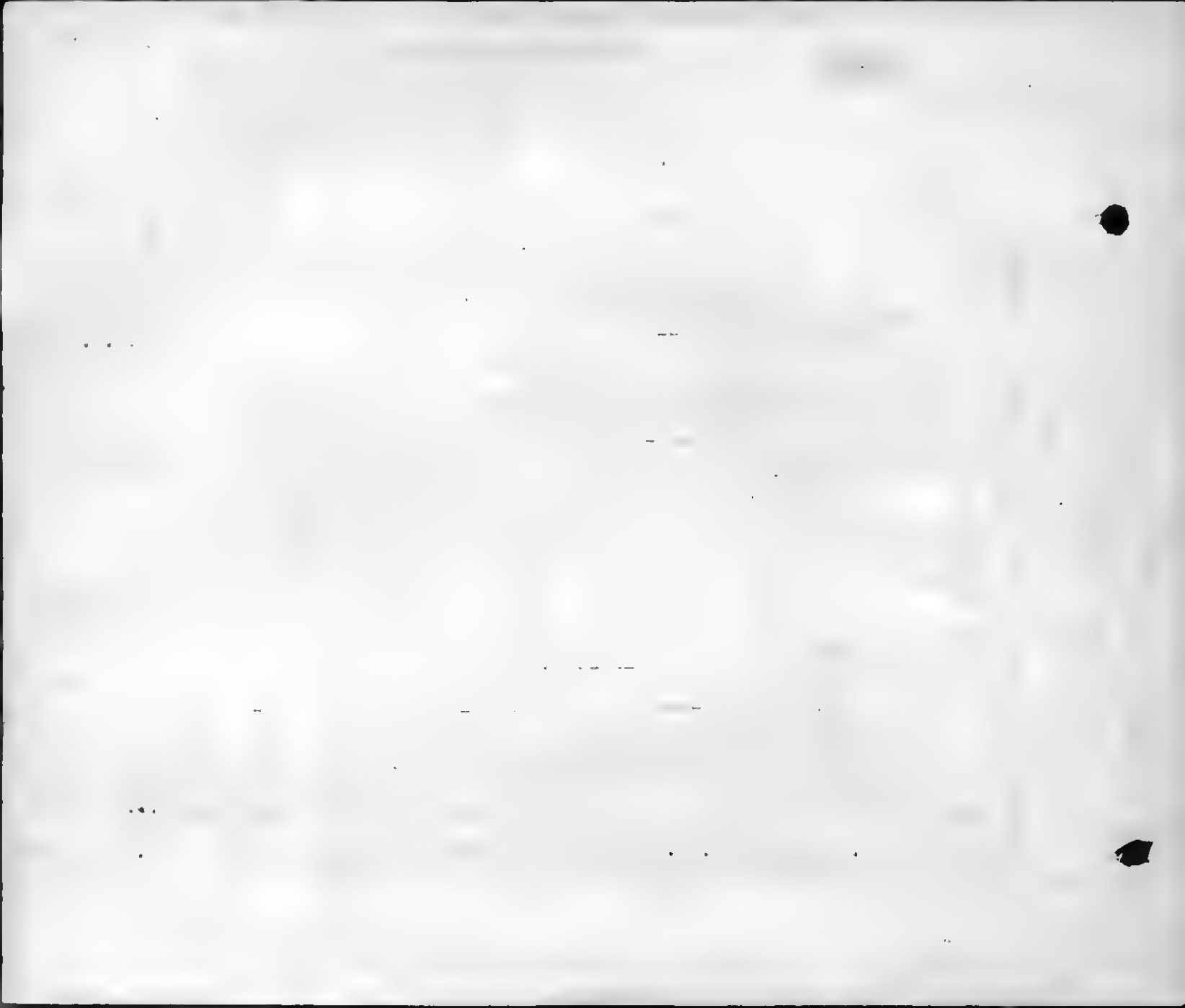
Reg. Dist. No.

9923

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 17 years 2mo. 13 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS Unknown e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Jessie Mitchell				4. DATE OF DEATH Month Day Year 9 13 1960			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH April 22, 1905		9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 55			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory Worker		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Eugene Mitchell		14. MOTHER'S MAIDEN NAME Elizabeth Gray			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO 219-01-7940		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Cervix with metastasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 11X DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----			
20f. (City or town) -----		20g. (County) -----		20h. (State) -----			
21. I certify that I attended the deceased from 6/30 , 19 43 , to 9/13 , 19 60 , that I last saw the deceased alive on 9/13 , 19 60 , and that death occurred at 1:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 9/13/60 ACTUAL SIGNATURE [Signature] M.D. PHYSICIAN'S NAME (Type) L. Benedict, M. D. Crownsville State Hospital, Md. 9/13/60							
22a. BURIAL CREMATION REMOVAL (Specify)		22b. DATE THEREOF 9-28-60		22c. NAME OF CEMETERY OR CREMATORY Wm. A. Beall			
22d. LOCATION (City, town, or county) Baltimore		22e. (State) Md.		22f. (Country) U.S.A.			
23. FUNERAL DIRECTOR'S SIGNATURE John R. Williams		23a. ADDRESS 22 Schuler St. Baltimore, Md.		24a. REC'D BY REGISTRAR SEP 27 '60			
24b. REGISTRAR'S SIGNATURE Arthur S. Fries							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 11/59

9924

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09884

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>		c. LENGTH OF STAY IN 1b <u>10</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Krollmeyer Manor</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Orange</u>	
d. STREET ADDRESS <u>?</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Morris</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>8</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 12, 1866</u>
9. AGE (In years last birthday) <u>94</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>	
11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Morris</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>yes</u>		16. SOCIAL SECURITY NO. <u>18-10-3022</u>	
17. INFORMANT <u>William N. Morris</u>		Address <u>Foreign Post Box 88</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral infarction</u> DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>about 5 years</u> (b) <u>Coronary atherosclerosis</u> DUE TO <u>about 24 years</u> (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Extensive Carcinoma Left Ear</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>6/17/60</u> to <u>9/8-60</u> , that (I) (we) last saw the deceased alive on <u>9/7/60</u> , and that death occurred on <u>9/8/60</u> at <u>11:00 AM</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Joseph Lipskey</u> M.D.		22b. DATE SIGNED <u>9/8-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH LIPSEY</u>		22d. ADDRESS <u>ODEH TOWN, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-12-1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Edna Ridge</u>		23d. LOCATION (City, town, or county) (State) <u>Bethesda Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Larry Byers</u>		25a. REC'D BY REGISTRAR <u>SEP 14 '60</u>	
ADDRESS <u>8778 Lehigh Rd. Randallstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	



9925

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 3mo. 41 yrs. 23 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS Unknown			
3. NAME OF DECEASED (Type or print) First Catherine Middle Parker Last Parker				4. DATE OF DEATH Month 9 Day 28 Year 1960			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1879	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundress				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure							
DUE TO Myocardial Infarction							
DUE TO Coronary Arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) -----			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) -----				20g. (County) -----		20h. (State) -----	
21. I certify that I attended the deceased from 6/5 , 19 19 , to 9/28 , 19 60 , that I last saw the deceased alive on 9/28 , 19 60 , and that death occurred at 3:50 P. M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 9/29/60							
ACTUAL SIGNATURE [Signature]				M.D. Crownsville State Hospital, Md. 9/29/60			
PHYSICIAN'S NAME (Type) L. Benedict, M. D.				Crownsville State Hospital, Md. 9/29/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-4-60		22c. NAME OF CEMETERY OR CREMATORY Asbury		22d. LOCATION (City, town, or county) (State) ANNAPOLIS - Md	
23. FUNERAL DIRECTOR'S SIGNATURE E. E. Hicks				ADDRESS ANNAPOLIS, MD		24a. REC'D BY REGISTRAR DATE OCT 10 1960	
				24b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

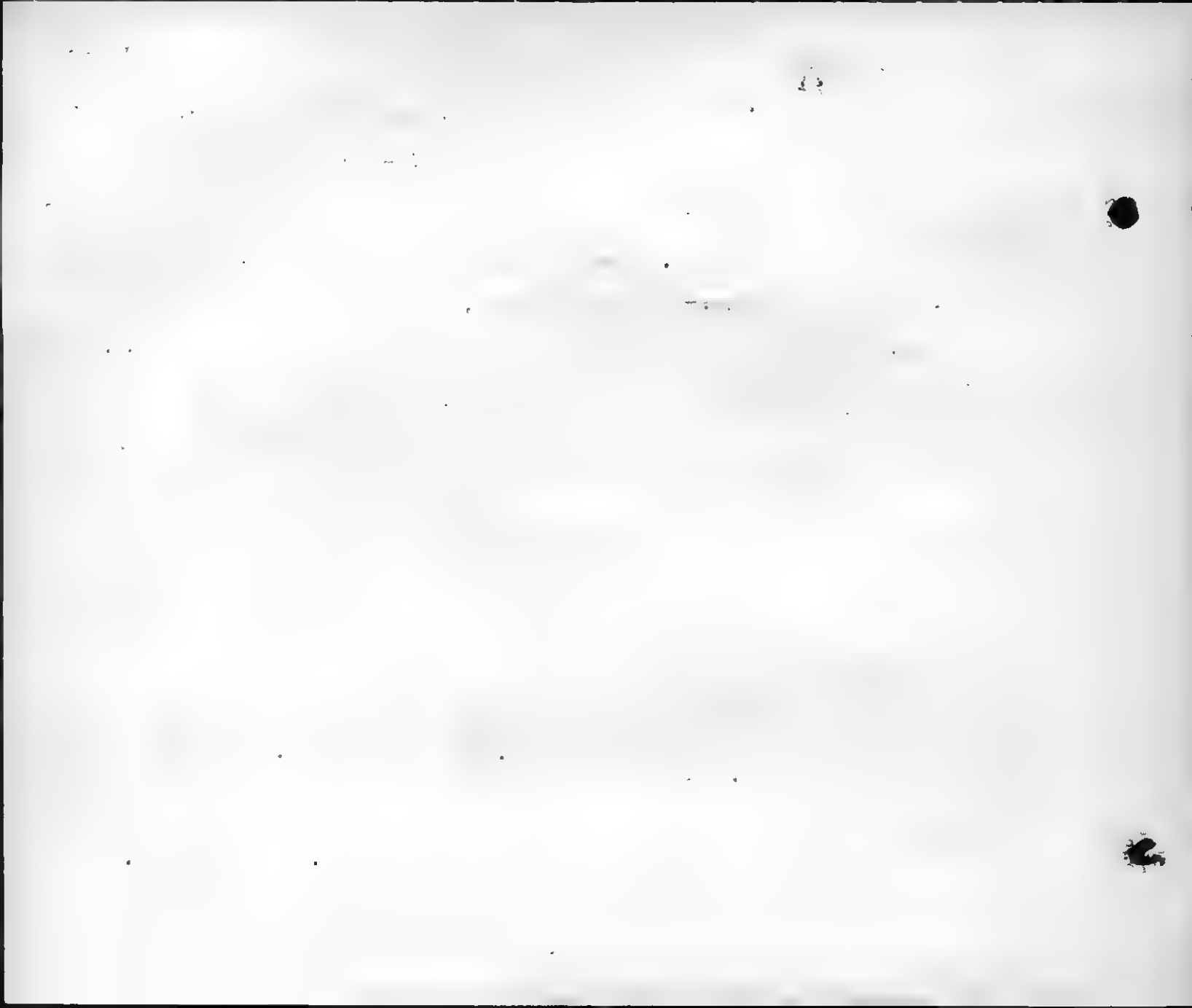
9889

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09886

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>2601-4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Homewood Convalescent Home</u>		d. STREET ADDRESS <u>1350 Pentwood Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Fanny</u> Middle <u>H.</u> Last <u>PARKER</u>		4. DATE OF DEATH Month <u>September</u> Day <u>23</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 15-1875</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Bedford, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Abner Hackworth</u>		14. MOTHER'S MAIDEN NAME <u>Susan Byrd</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-14-0416</u>	
17. INFORMANT <u>John J. G. L. 225 E. ...</u>		Address <u>Alexandria, Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>ARTERIOSCLEROSIS, GENERALIZED</u> DUE TO (c) <u>UNKNOWN</u>		INTERVAL BETWEEN ONSET AND DEATH <u>72 HOURS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/19, 1960</u> to <u>9/23, 1960</u> that (I) (we) last saw the deceased alive on <u>9/22, 1960</u> , and that death occurred at <u>8 A. M.</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Edward S. Beck</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>71 Franklin St., Annapolis</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-26-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Columbia Gardens</u>		23d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles ...</u>		25a. REC'D BY REG. STRAR <u>SEP 26 '60</u>	
ADDRESS <u>Arlington, Va.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>	





VS A1S (4)
15M 10/57

1. PLACE OF DEATH a. COUNTY <u>A A</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md.</u>		b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHURCHTON</u>		c. LENGTH OF STAY IN 1b <u>68 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Churchton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HORACE E. Phipps</u>				4. DATE OF DEATH Month Day Year <u>Sept 7 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/30/92</u>	9. AGE (In years last birthday) <u>68</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General carpenter</u>		11. BIRTHPLACE (State or foreign country) <u>Churchton Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Edward Phipps</u>				14. MOTHER'S MAIDEN NAME <u>Beulah Johnson Ph Nell Randall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) If yes, give war or dates of service <u>No</u>		16. SOCIAL SECURITY NO. <u>218129076</u>		17. INFORMANT Address <u>Beulah Johnson Phipps Churchton Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X Cardiac Failure</u> DUE TO (b) <u>Arteriosclerosis C.V.R. Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> <u>None</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Nothing, Arterio Tbc, Chr Bronchitis, Emphysema</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <u>Mar</u> , 19 <u>50</u> to <u>7 Sept</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7 Sept</u> , 19 <u>60</u> , and that death occurred at <u>5:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>7 Sept 60</u> ACTUAL SIGNATURE <u>P. H. Hasser</u> M.D. _____ PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/10/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodfield</u>		22d. LOCATION (City, town, or county) <u>Wadesville</u>		(State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardaway</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 15 '60</u>		24b. REGISTRAR'S SIGNATURE <u>C. J. H. Hasser</u>	



9900

CERTIFICATE OF DEATH

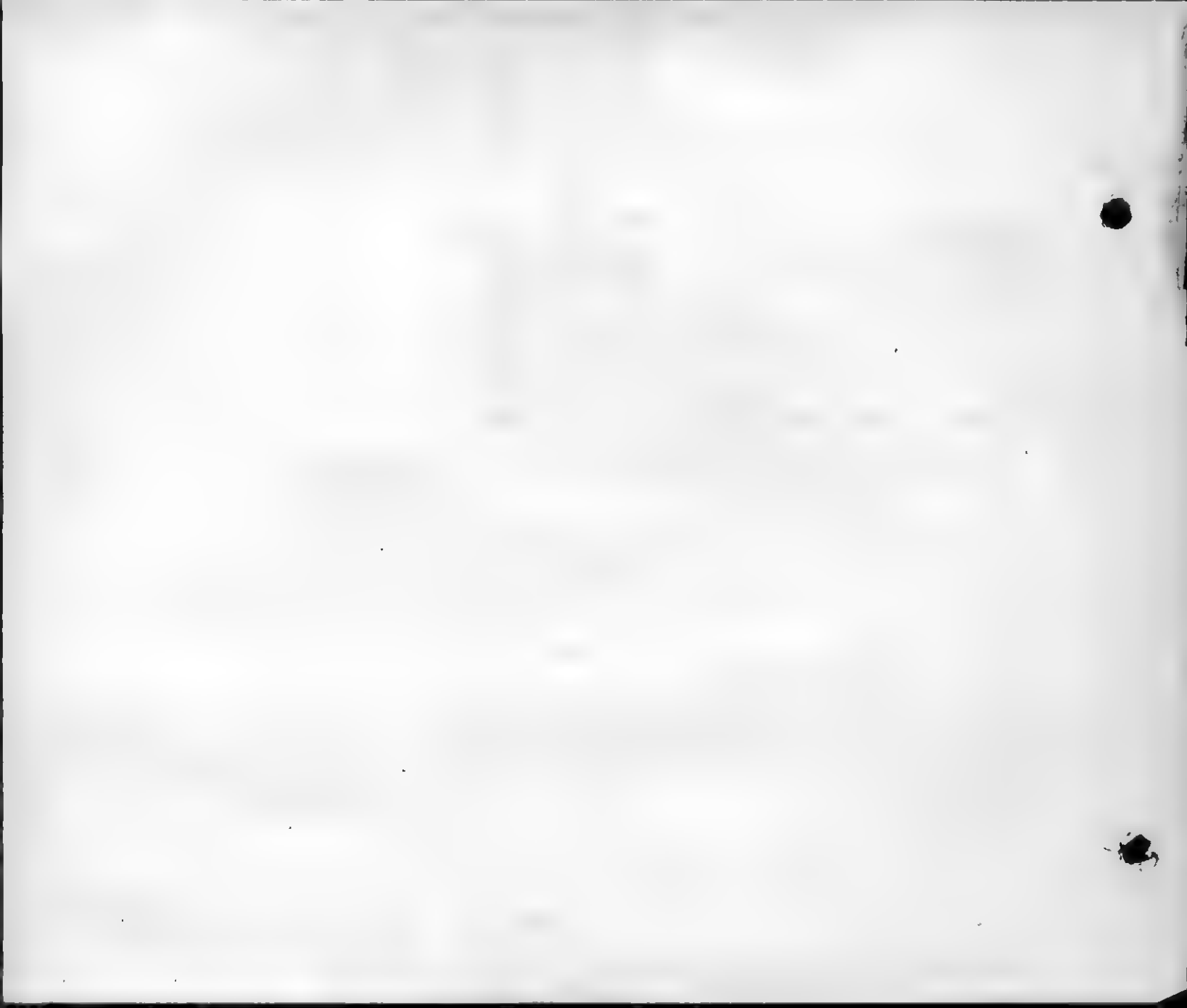
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>MD.</u> c. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEVERNA PARK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Med</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Joseph Bogie</u>		4. DATE OF DEATH Month <u>9</u> - Day <u>9</u> - Year <u>1960</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 28, 1954</u>
9. AGE (In years last birthday) <u>78</u> yrs		10. IF UNDER 1 YEAR: Months <u>9</u> Days <u>9</u> Hours <u>19</u> Min <u>60</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food</u>	
11. BIRTHPLACE (State or foreign country) <u>COLORADO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Wm Bogie</u>		14. MOTHER'S MAIDEN NAME <u>Mary SHIELDS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>no</u>	
17. INFORMANT <u>Daughter</u>		Address <u>ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>myocardial infarction</u> DUE TO (c) <u>Hypertensive C.V. disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1958</u> to <u>1960</u> , that I last saw the deceased alive on <u>9-9-60</u> , and that death occurred at <u>4:45</u> P.M. from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Robert R. Hahn</u>		ADDRESS (Street, city or town, state) <u>Severna Park, MD.</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT R. HAHN</u>		DATE SIGNED <u>MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-13-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. PATRICK'S CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>BUTTE, MONTANA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert S. Barnard</u>		24a. REC'D BY REGISTRAR <u>SEP 13 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9927 CERTIFICATE OF DEATH

09890

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNA Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN 1b <u>6 yrs. 2mo. 17 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> d. STREET ADDRESS <u>Unknown</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Maria</u> Last <u>Ridgley</u>				4. DATE OF DEATH Month <u>9</u> Day <u>30</u> Year <u>1960</u>													
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1904</u>		9. AGE (In years last birthday) <u>56</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS	Months	Days		Hours		Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS																
Months	Days																
	Hours																
	Min.																
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Hen Ridgley</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Disley</u>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <u>Unknown</u>				16. SOCIAL SECURITY NO <u>Unknown</u>		17. INFORMANT <u>Hospital Records</u> Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <u>42001</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Hypertensive Cardiovascular Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>-----</u>													
20c. TIME OF INJURY Hour <u>a. m.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>		20f. (City or town) (County) (State) <u>-----</u>									
21. I certify that I attended the deceased from <u>7/13</u> , 19 <u>54</u> , to <u>9/30</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>9/30</u> , 19 <u>60</u> , and that death occurred at <u>3:50 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md.</u> DATE SIGNED <u>10/3/60</u> ACTUAL SIGNATURE <u>[Signature]</u> M.D. PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u> <u>Crownsville State Hospital, Md.</u> <u>10/3/60</u>																	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				22b. DATE THEREOF <u>10/5/60</u>		22c. CEMETERY OR CREMATION <u>University of Md</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>Md</u>									
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Kasse II</u> Address <u>Chesapeake, Md</u>						24a. REC'D BY REGISTRAR <u>0016 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kasse</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9928

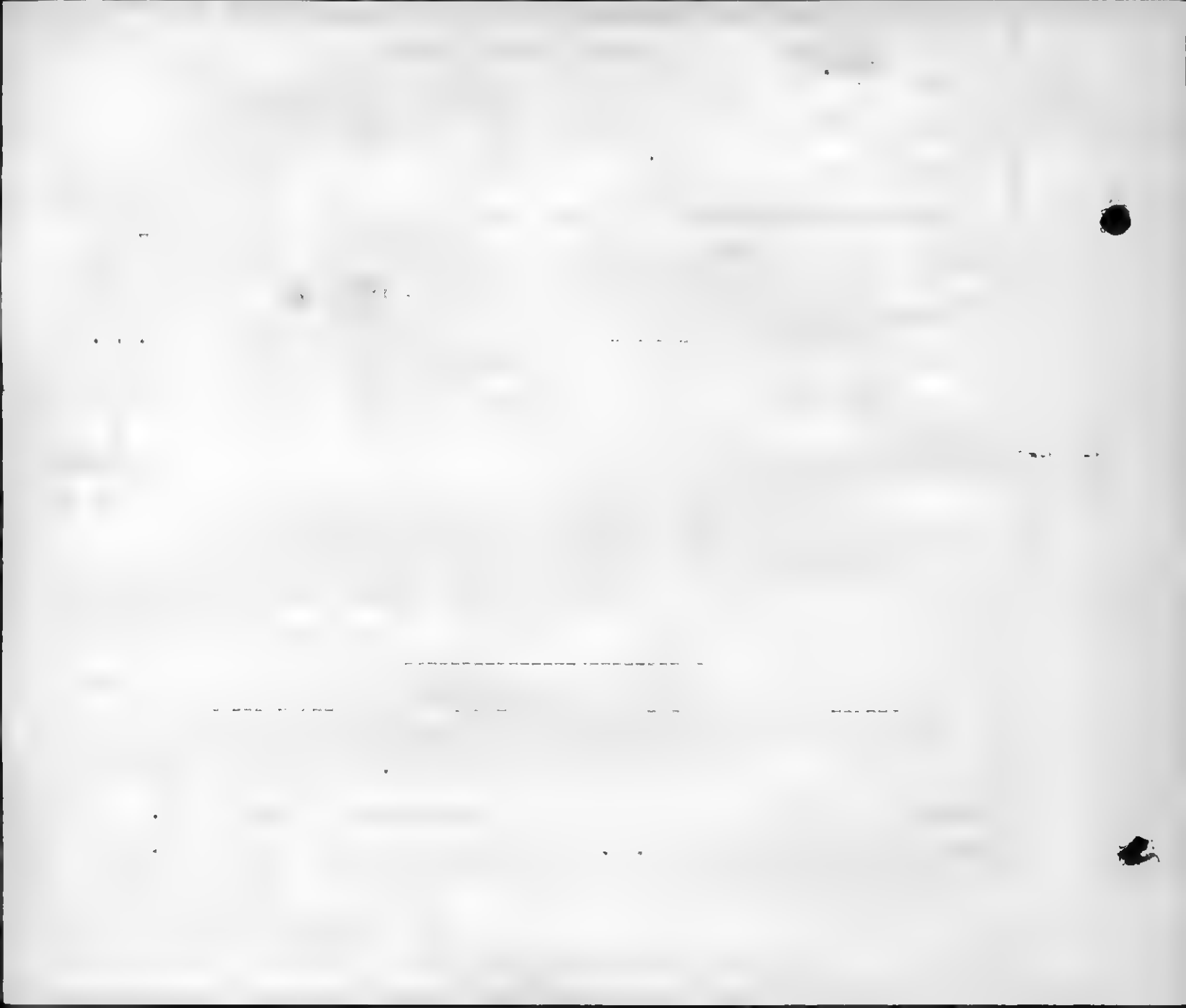
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN TB 1mo. 15 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1601 Bruce Court • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Charles Edward Russell				4. DATE OF DEATH Month Day Year 9 27 60			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 18, 1885	
9. AGE (In years last birthday) 75		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown Laborer		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alfred Russel				14. MOTHER'S MAIDEN NAME Jane?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory Failure DUE TO Arteriosclerosis, Generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO (b) (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Psychosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/12 , 19 60 , to 9/27 , 19 60 , that I last saw the deceased alive on 9/27 , 19 60 , and that death occurred at 6:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Crownsville State Hospital, Md. 9/27/60 ACTUAL SIGNATURE Lionel McHenry Mapp M.D. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D. Crownsville State Hospital, Md. 9/27/60							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
10/7/60		10/7/60		Baltimore, Md.		Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE 322 Paul R. Williams				24a. REC'D BY REGISTRAR DATE SEP 29 '60		24b. REGISTRAR'S SIGNATURE Charles L. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

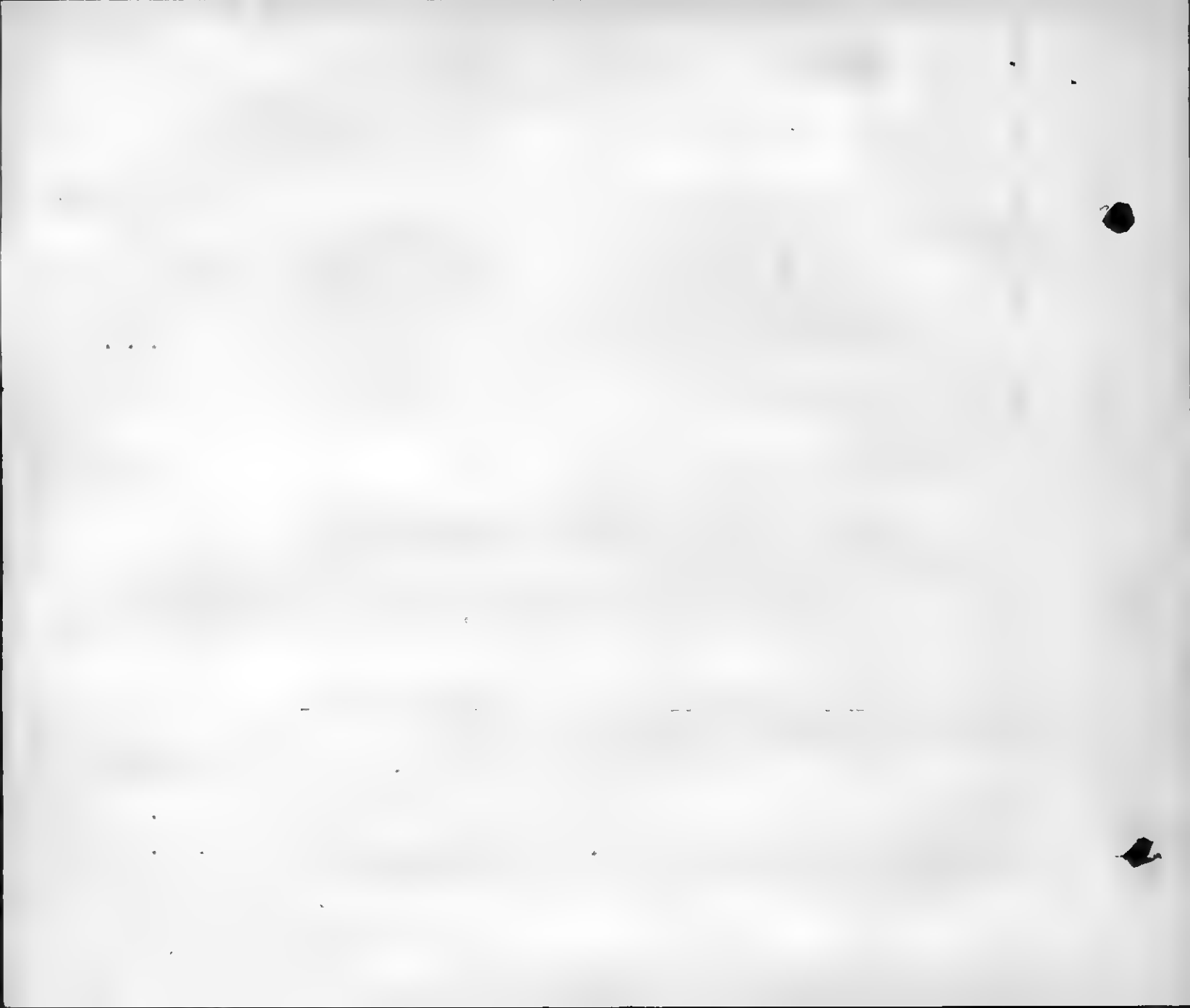
69892

9929

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN b 29 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminister d. STREET ADDRESS Unknown e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Preston Snowden				4. DATE OF DEATH Month Day Year 9 4 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Unknown		8. DATE OF BIRTH 1878	
9. AGE (In years last birthday) 82 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Unknown	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarct DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) Senility							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cystitis due to Benign Prostatic Hypertrophy, Chronic Brain Syndrome Secondary to Cerebral Arteriosclerosis, Senility							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) -----					
20c. TIME OF INJURY Hour a. m. p. m. ----- 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from 8/5 , 19 60 , to 9/4 , 19 60 , that I last saw the deceased alive on 9/4 , 19 60 , and that death occurred at 8:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Crownsville State Hospital, Md. 9/6/60							
ACTUAL SIGNATURE Lionel McHenry Mapp		M.D. Crownsville State Hospital, Md. 9/6/60					
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		Crownsville State Hospital, Md. 9/6/60					
22a. BIRTHPLACE (State or foreign country) Remond, 19160, Md.		22b. DATE THEREOF 9/19/60		22c. NAME OF CEMETERY OR CREMATORY Union of Maryland		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Reese H. Granger				ADDRESS Baltimore, Md.		24a. REC'D BY REGISTRAR SEP 13 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
2

9930

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09893

1. NAME OF DECEASED (Type or Print) Anne Stoll		2. DATE OF DEATH 9/11/60	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Brooklyn County FULL NAME OF HOSPITAL OR INSTITUTION 1356 Sixth St.		4. USUAL RESIDENCE (Where deceased lived) a. STATE Md. b. COUNTY A.A. c. CITY OR TOWN Brooklyn d. STREET ADDRESS 1356 Sixth St.	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 12/7/12
9. AGE (In years last birthday) 47		10. A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jos. Ocek		14. MOTHER'S MAIDEN NAME -	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Family		ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death) CAUSE OF DEATH (A) Pulmonary Edema DUE TO Coronary Insufficiency (B) Mitral Insufficiency DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 41			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
21. IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		22. DATE OF OPERATION	
23. CONDITION FOR WHICH OPERATION WAS PERFORMED		24. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
25. I certify that (I) (this hospital) attended the deceased from 7-14 1960 to 9-13 1960 and that in (my) (our) opinion death occurred at 10 A m, from the causes and on the date stated above.			
26. SIGNATURE Eugene Schuch		27. ADDRESS 3904 S. Hanover St.	
28. DATE 9/19/60		29. DATE SIGNED 9-15-60	
30. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		31. LOCATION (City, town, or county) (State) Balto. 25, Md.	
32. DATE REC'D BY HEALTH DEPT. 9/28/60		33. NAME OF REGISTRAR McGully Funeral Homes	
34. FUNERAL DIRECTOR McGully Funeral Homes		35. ADDRESS 130 E. Fort Ave. jhh	

CERTIFICATION

1

24a. BURIAL, CREMATION, REMOVAL (Specify)
Burial

24b. DATE
9/19/60

24c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem.

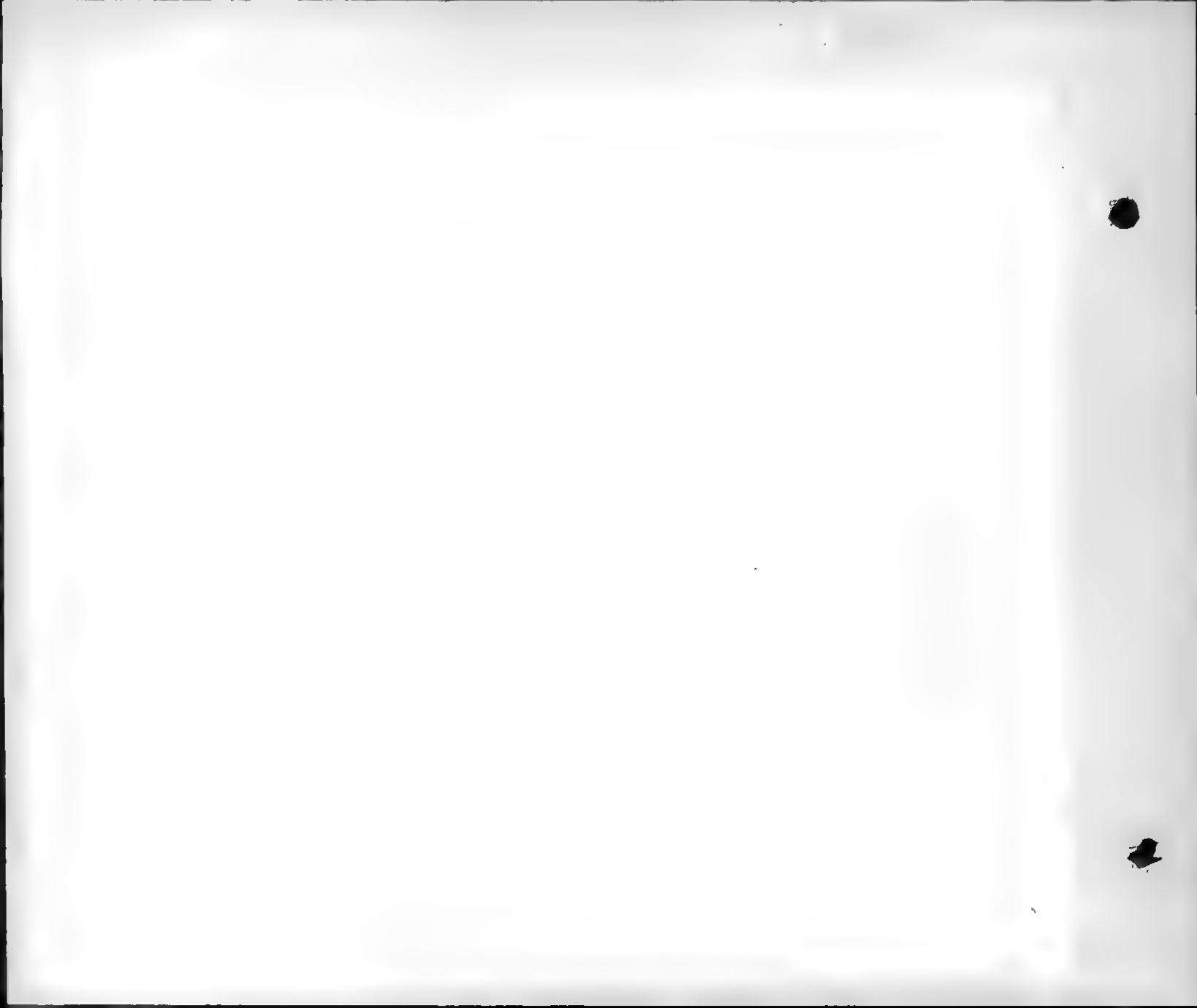
24d. LOCATION (City, town, or county) (State)
Balto. 25, Md.

25a. DATE REC'D BY HEALTH DEPT.
9/28/60

25b. NAME OF REGISTRAR
McGully Funeral Homes

25c. FUNERAL DIRECTOR
McGully Funeral Homes

ADDRESS
130 E. Fort Ave. jhh



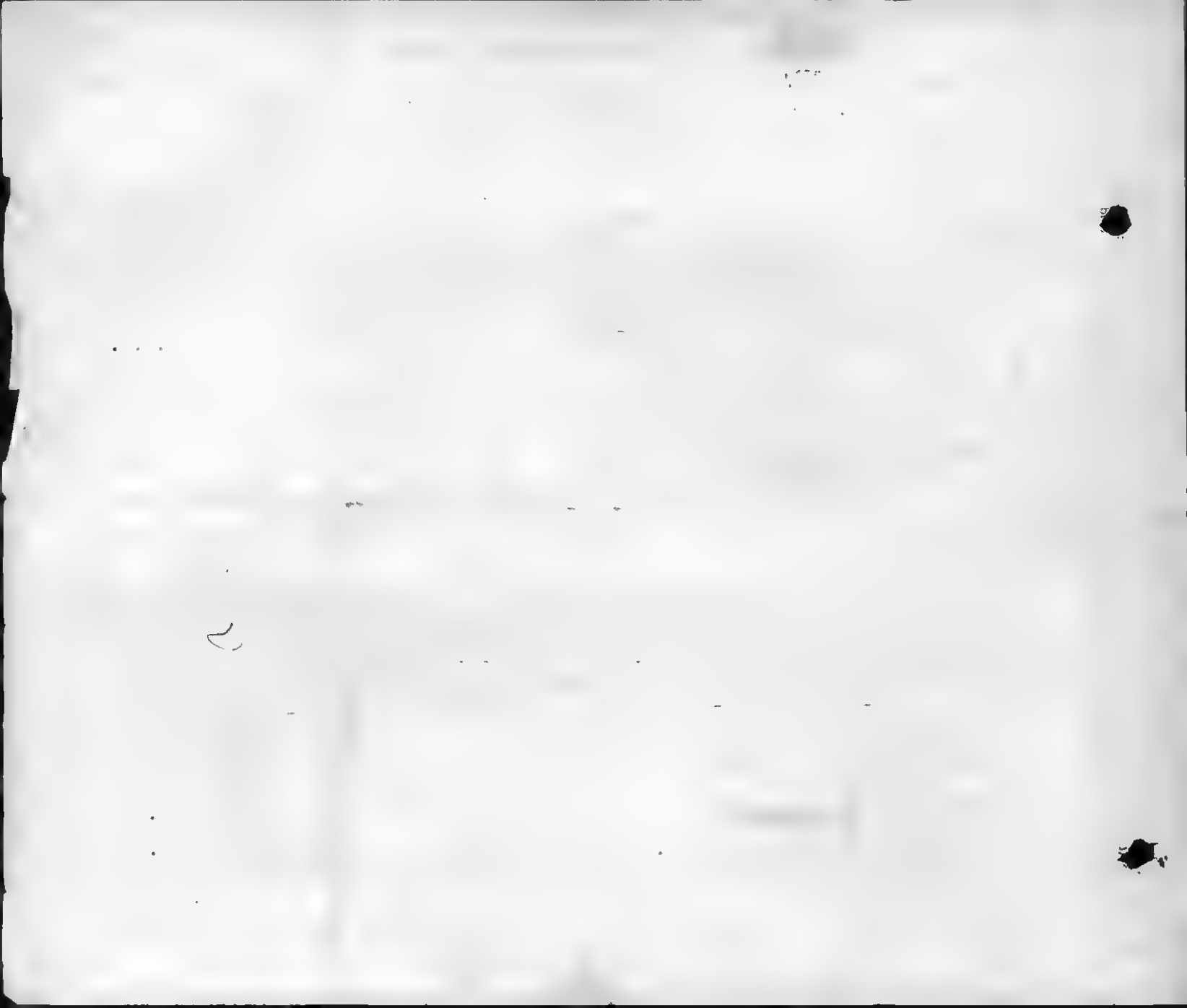
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9931
CERTIFICATE OF DEATH

09894

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN 1b <u>28 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				e. STREET ADDRESS <u>12 Pleasant Court</u>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Milton</u> Middle <u>Paul</u> Last <u>Thompson</u>				4. DATE OF DEATH Month <u>9</u> Day <u>28</u> Year <u>19 60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 26, 1917</u>	
9. AGE (In years lost birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Storekeeper</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Selman Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Holland</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inanition and Dehydration</u> DUE TO <u>309X</u> Conditions, if any, which gave rise to immediate cause (b) <u>Psychotic Depressive Reaction</u> (c) <u>-----</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-----</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>-----</u>							
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While <u> </u> at work <input type="checkbox"/> while <u> </u> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>		20f. (City or town) (County) (State) <u>-----</u>	
21. I certify that I attended the deceased from <u>8/30</u> , 19 <u>60</u> , to <u>9/28</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>9/28</u> , 19 <u>60</u> , and that death occurred at <u>6:45 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md.</u> DATE SIGNED <u>9/28/60</u>							
ACTUAL SIGNATURE <u>L. Benedict, M. D.</u>				PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-2-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Churchton</u>		22d. LOCATION (City, town, or county) (State) <u>A.A. Co. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hilds III</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 10 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9932
CERTIFICATE OF DEATH

09895

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Baltimore City ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
c. LENGTH OF STAY IN 1b 4 mo. 6 days				d. STREET ADDRESS 1031 W. Fayette Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lelia Middle Tillman Last Tillman				4. DATE OF DEATH Month September Day 15 Year 1960			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 13, 1920	
9. AGE (In years last birthday) 39 yrs		IF UNDER 1 YEAR Months 39 Days 15 Hours 15 Min 15		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		11. BIRTHPLACE (State or foreign country) North Carolina	
10b. KIND OF BUSINESS OR INDUSTRY -----		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Phillip Tillman			
14. MOTHER'S MAIDEN NAME Lela Pearl Tillman		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Kachexia 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Squamous cell carcinoma of the bladder DUE TO (c) -----				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Paranoid Reaction				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) -----			
20c. TIME OF INJURY Month, Day, Year Hour a.m. ----- p.m. ----- 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 21 , 19 60 , to Sept. 15 , 19 60 , that I last saw the deceased alive on Sept. 15 , 19 60 , and that death occurred at 11:10 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital DATE SIGNED L. Benedict, M.D.							
ACTUAL SIGNATURE L. Benedict, M.D.				M.D. Crownsville State Hospital			
PHYSICIAN'S NAME (Type) L. Benedict, M.D.				Crownsville State Hospital			
22a. BURIAL, CREMATION, REPOSAL (Type)		22b. DATE THEREOF 9-17-60		22c. NAME OF CEMETERY OR CREMATORY Charlotte M.C.		22d. LOCATION (City, town or county) (State) Charlotte M.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Williams				24a. REC'D BY REGISTRAR DATE SEP 19 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Williams	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be used by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9933

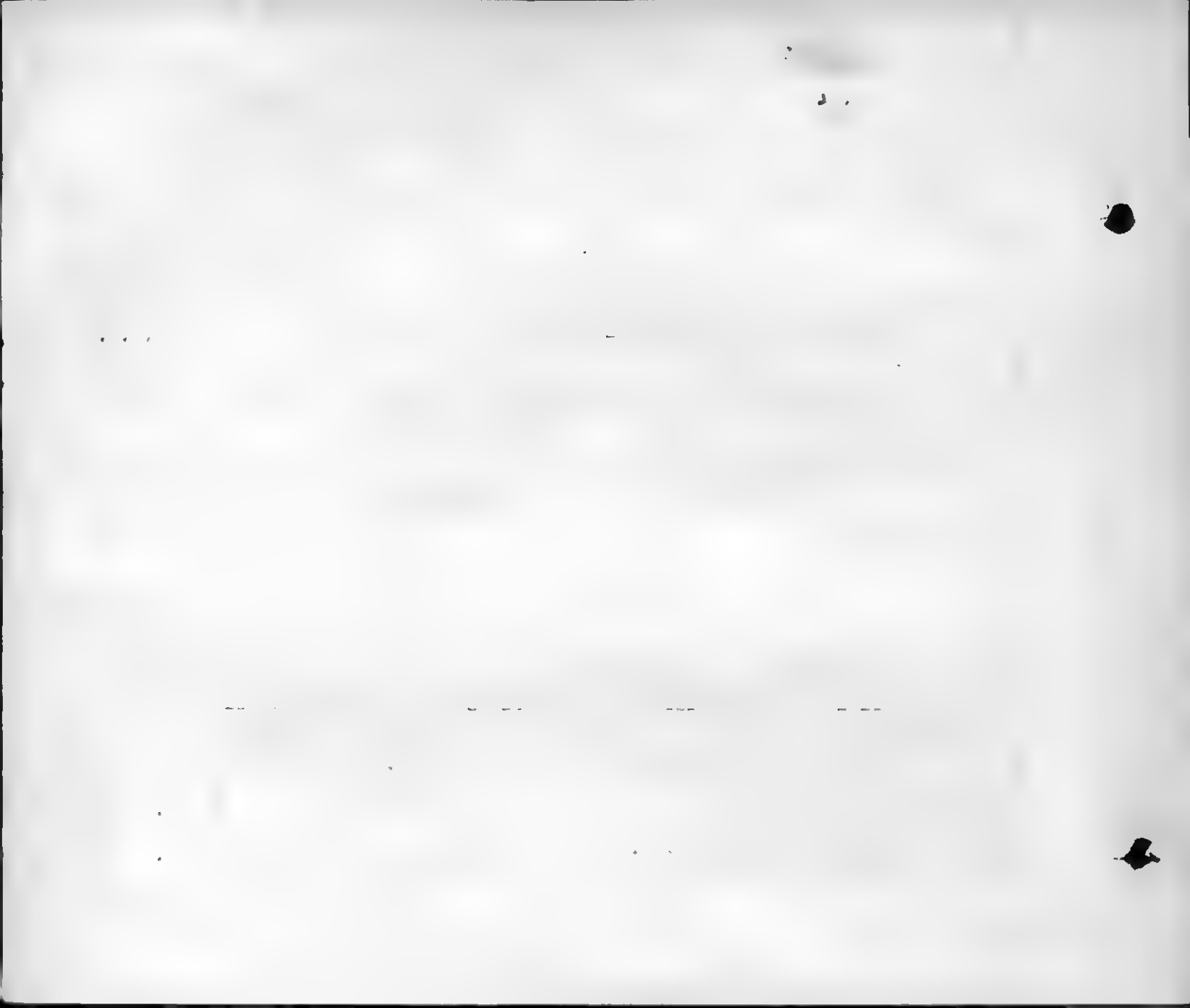
CERTIFICATE OF DEATH

Reg. Dist. No. 09896

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 1 mo. 3 years 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 5233 Denmore Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Sarah Middle Bell Last Timpson				4. DATE OF DEATH Month 9 Day 17 Year 1960			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1872-April	
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months 8 Days 17 Hours 17 Min 17		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Unknown Housewife				10b. KIND OF BUSINESS OR INDUSTRY -----			
13. FATHER'S NAME Unknown John Jones				14. MOTHER'S MAIDEN NAME Unknown Louisa ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Arteriosclerotic Cardiovascular Disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ----- DUE TO (c) -----				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) -----			
20c. TIME OF INJURY Month ----- Day 19 Year 1960 Hour ----- a. m. ----- p. m. -----				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) -----				20g. (County) -----		20h. (State) -----	
21. I certify that I attended the deceased from 3/8 , 19 57 , to 9/17 , 19 60 , that I last saw the deceased alive on 9/17 , 19 60 , and that death occurred at 10:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 9/19/60							
ACTUAL SIGNATURE L. Benedict, M. D.				PHYSICIAN'S NAME (Type) L. Benedict, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9-22-60		22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn	
22d. LOCATION (City, town, or county) Baltimore				22e. (State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Mary R. Walling				ADDRESS 3223 Schrock St		24a. REC'D BY REGISTRAR SEP 22 '60	
24b. REGISTRAR'S SIGNATURE Chas. E. H.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The funeral director, may be filled by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

(1)

(1)

9934

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09897

1. PLACE OF DEATH a. COUNTY <i>a a</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>a a</i>			
3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Davidsonville</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>PT 424</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>William Wellington Townsend</i>				4. DATE OF DEATH Month Day Year <i>9 - 18 1960</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10 - 12 - 1875</i>	9. AGE (In years lost birthday) <i>84</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Potomac Dairy</i>		11. BIRTHPLACE (State or foreign country) <i>Pri Geo Co Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>William P. Townsend</i>				14. MOTHER'S MAIDEN NAME <i>Mary C. Thompson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT Address <i>Pearl M. Townsend</i>		(2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple Stroke</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <i>arteriosclerosis, generalized</i> DUE TO (c) <i>hypertension</i>							INTERVAL BETWEEN ONSET AND DEATH <i>1 min</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>BPH. & obstruction</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>July 15, 1960</i> to <i>Sept 18, 1960</i> , that (I) (we) last saw the deceased alive on <i>Sept 16, 1960</i> , and that death occurred at <i>1 AM</i> , from the causes and on the date stated above							
22a. SIGNATURE <i>Frank M Shipley</i>		M. D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>9-18-60</i>			
22c. PHYSICIAN'S NAME (Type) <i>Frank M Shipley</i>		22d. ADDRESS <i>Annapolis, Md</i>					
23a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>9-20-1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>All Hallows Cent</i>		23d. LOCATION (City, town, or county) (State) <i>Davidsonville Md</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Gale M. Taylor</i>		ADDRESS <i>Sims Annapolis Md</i>		25a. REC'D BY REGISTRAR <i>SEP 21 '60</i>		25b. REGISTRAR'S SIGNATURE <i>William S. Hines</i>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4

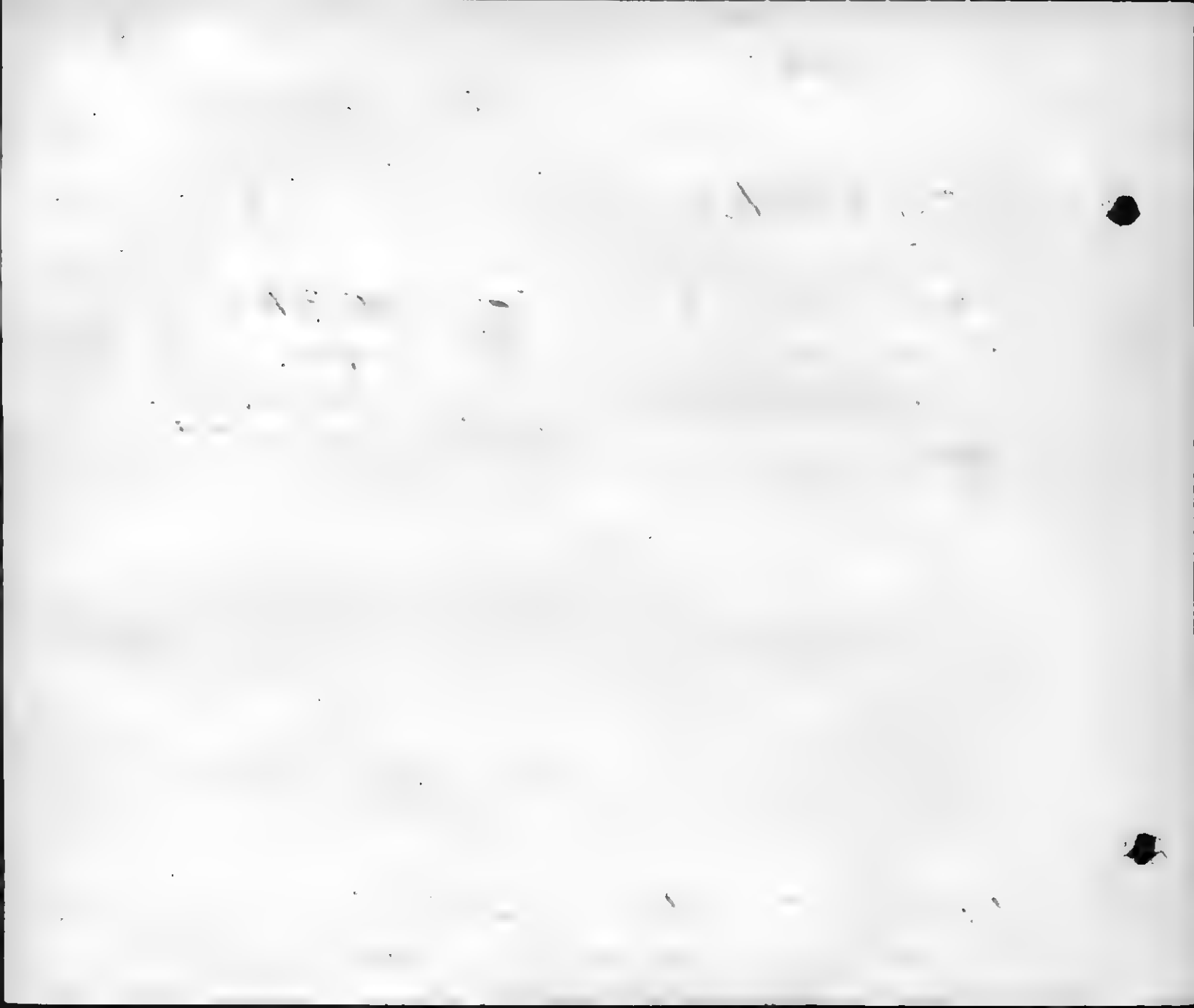
may be filled by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09898

9891

1. PLACE OF DEATH a. COUNTY <i>A. A.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <i>Maryland</i> COUNTY <i>A. A.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. LENGTH OF STAY IN 1b <i>Annapolis 10</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>63 College Ch. Seneca</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Louise Helen Turner</i>				4. DATE OF DEATH Month <i>9</i> Day <i>26</i> Year <i>1960</i>			
5 SEX <i>Female</i>	6 COLOR OR RACE <i>Col</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>12-14-1920</i>	9 AGE (In years last birthday) <i>39</i> yrs.	IF UNDER 1 YEAR Months <i></i> Days <i></i>	IF UNDER 24 HRS Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>		11. BIRTHPLACE (State "sign count") <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Turner</i>				14. MOTHER'S MAIDEN NAME <i>Helen Bell</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i></i>		17. INFORMANT <i>Lorine Brown 63 College Ch. Seneca</i> Address <i></i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Pulmonary Edema</i> <i>199.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Generalized Convulsions</i> DUE TO (c) <i></i>						INTERVAL BETWEEN ONSET AND DEATH <i>1 hr. - 6 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Top</i>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>9/26/60</i> to <i>9/26/60</i> that (I) (we) last saw the deceased alive on <i>9/26/60</i> and that death occurred at <i>11 A.M.</i> from the cause and on the date stated above.				22. DATE SIGNED <i>9/29/60</i>			
22a. SIGNATURE <i>R. R. Richardson</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <i>110-Cl. St. Finner Park, Md.</i>			
22c. PHYSICIAN'S NAME (Type)							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 9-30-60</i>		23b. DATE THEREOF <i>9-30-60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Moses Cemetery, Brewer, Md.</i>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese Arena, Md.</i>				25a. REC'D BY REGISTRAR <i></i> DATE <i>SEP 29 1960</i>		25b. REGISTRAR'S SIGNATURE <i></i>	



1

9892

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09899

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Earleigh Heights	
3. NAME OF DECEASED (Type or print) First Andrew Middle VAN Last ORSDALE		4. DATE OF DEATH Month September Day 12 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 14, 1905
9. AGE (In years last birthday) 55 yrs		10. IF UNDER 1 YEAR Months 55 Days 55 Hours 55 Min. 55	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Concrete Block	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unk. C.T. VANORSDALE		14. MOTHER'S MAIDEN NAME Unk	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Jesse James Corbin, same as 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple fractures of pelvis, ribs - laceration of bladder DUE TO (b) Brutal bronchopneumonia DUE TO (c) Old coronary thrombosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fatty Liver		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Was struck by car	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 9 p. m. 3 19 60		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ROAD		20f. (City or town) RURAL (County) AA MD (State)	
21. I certify that (I) (physician) attended the deceased from Sept. 3, 19 60 to Sept. 11, 19 60 that (I) (last) saw the deceased alive on Sept. 11, 19 60 , and that death occurred at M. from the causes and on the date stated above.			
22a. SIGNATURE Henry W. Scheye		22b. ADDRESS 3230 Mountain Road, Pasadena, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/15/60	
23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley		25a. REC'D BY REGISTRAR SEP 16 '60	
ADDRESS Glen Burnie, Md.		25b. REGISTRAR'S SIGNATURE Charles S. Krasner	



may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



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9893

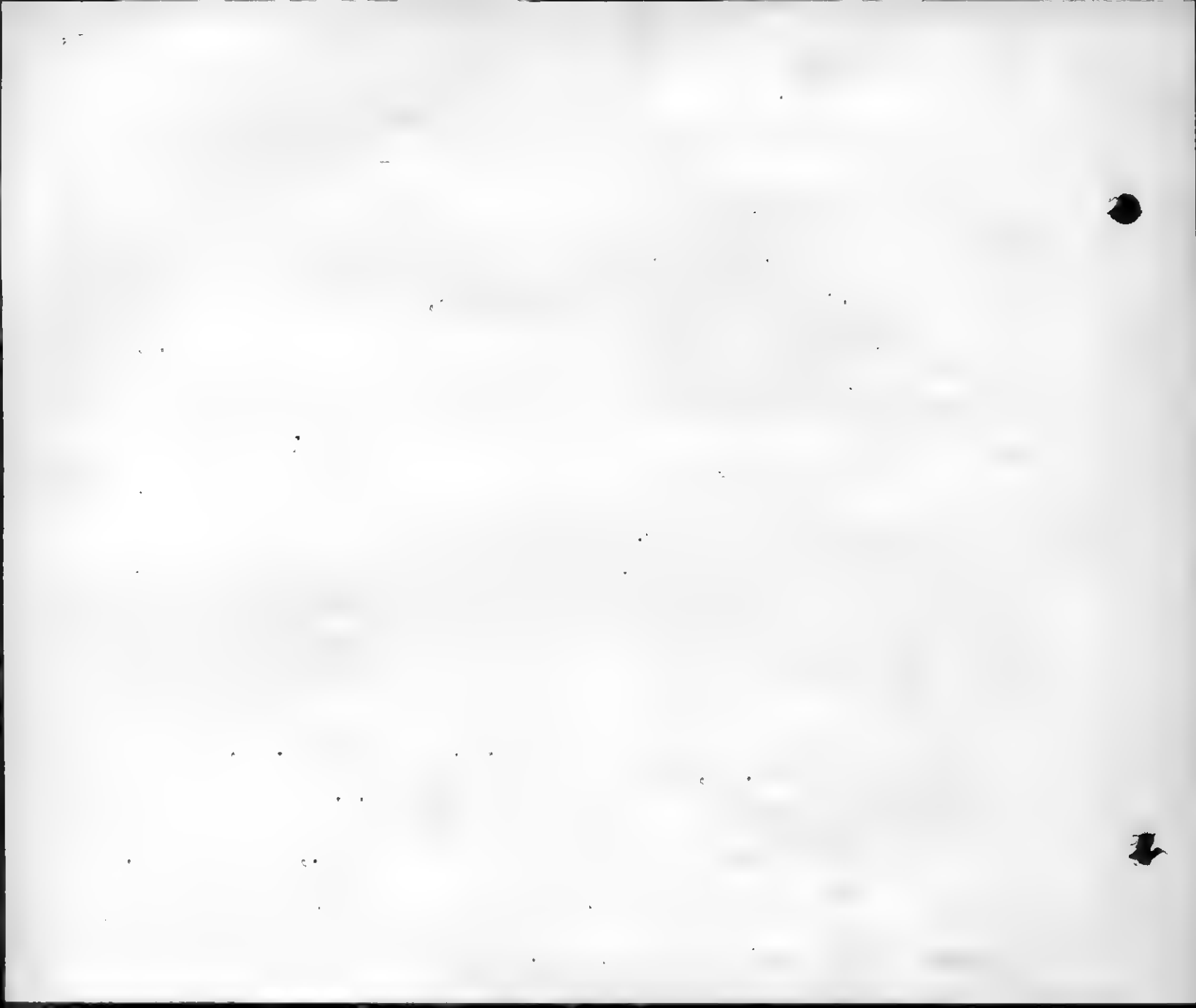
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09900

Item 7 Film 271 9-19-60 et

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle CHARLES Last WALLIS		4. DATE OF DEATH Month September Day 12 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1883
9. AGE (In years last birthday) 77 yrs		10. IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min 77	11. IF UNDER 24 HRS Months 77 Days 77 Hours 77 Min 77
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RAIL ROAD		10b. KIND OF BUSINESS OR INDUSTRY P.R.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Francis A. Wallis		14. MOTHER'S MAIDEN NAME Mary G. Willson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SECURITY NO 16	
17. INFORMANT MRS. JOHN A. WHEELER #2		Address #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure 527.1 DUE TO Ch. Emphysema & Bronchiectasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (extensive & advanced) (c) (extensive & advanced)			INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Sept. Day 6 Year 1960 Hour a. m. p. m. 12:35 P.M.	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 31 Southgate Ave., Annapolis, Md.	20f. (City or town) (County) (State)
21. I certify that (I) (Maurice Klawans) attended the deceased from Sept. 6, 1960 to Sept. 12, 1960 , that (I) was last saw the deceased alive on Sept. 12, 1960 , and that death occurred at 12:35 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Maurice Klawans		22b. DATE 9/12/60	
22c. PHYSICIAN'S NAME (Type) Maurice Klawans		22d. ADDRESS 31 Southgate Ave., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 9-14-60	23c. NAME OF CEMETERY OR CREMATORY St. John's Cem.	23d. LOCATION (City, town, or county) (State) Rock Hall MD.
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor		25a. REC'D BY REGISTRAR SEP 13 '60	
ADDRESS Son Annapolis MD		25b. REGISTRAR'S SIGNATURE Charles E. Francis	



CERTIFICATE OF DEATH

Reg. Dist. No.

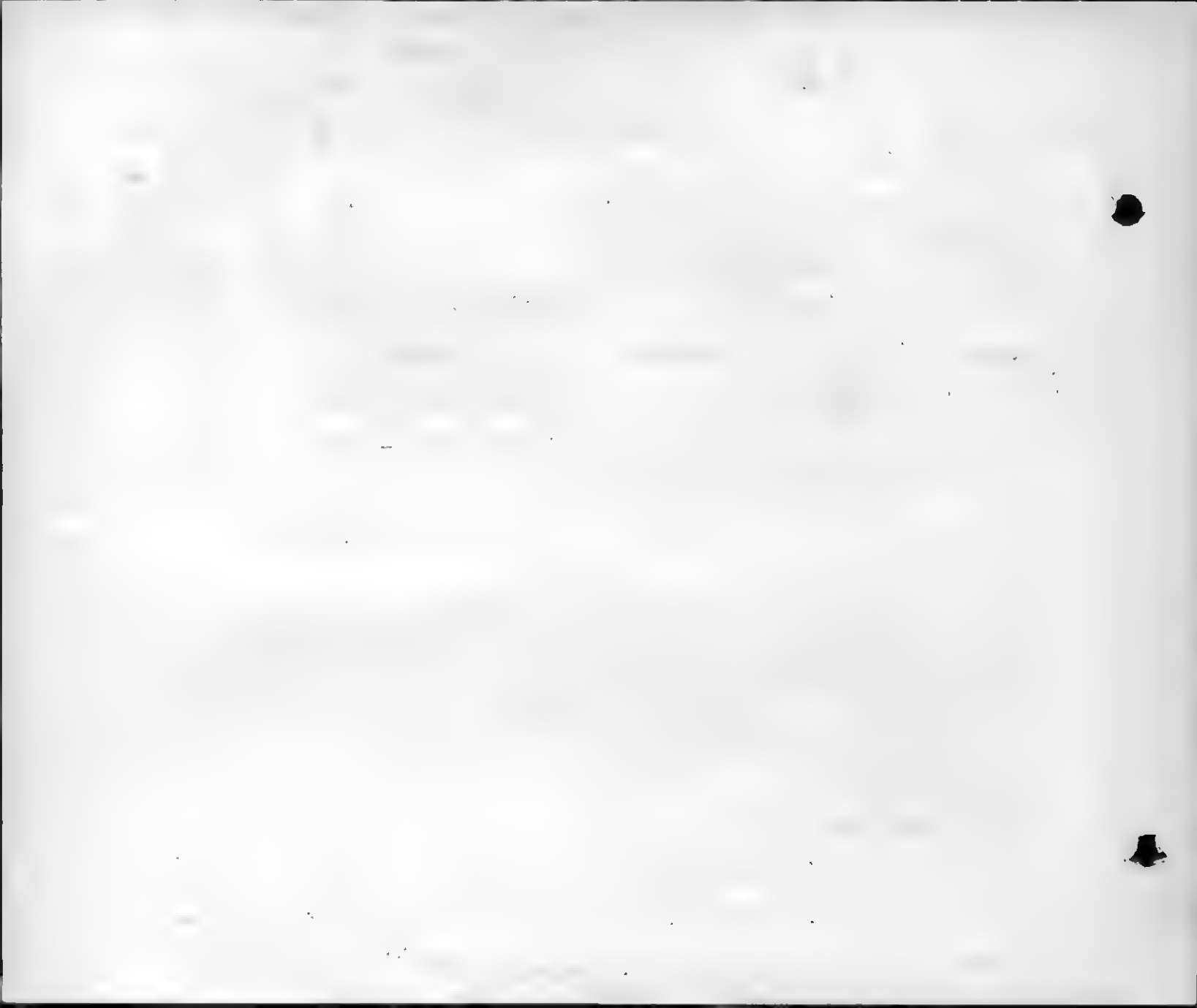
099901

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 10		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION DOA Anne Arundel General Hospital						d. STREET ADDRESS 220 West Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) MARGARET		First WARD		Middle WARD		Last WARD		4. DATE OF DEATH Month SEPTEMBER		Day 9	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 30, 1896		9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME Joseph Higgs						14. MOTHER'S MAIDEN NAME Mary Susan Center					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. no		17. INFORMANT William H. Ward- Husband - Same as # 2		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis											
DUE TO Arteriosclerotic Heart Disease											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from June 4, 1960 to Sept 9, 1960 , that I last saw the deceased alive on Sept 9, 1960 , and that death occurred at 4:15 P M, from the causes and on the date stated above.											
ADDRESS (Street, city or town, state)											
DATE SIGNED 9-10-60											
ACTUAL SIGNATURE James R. Martin M.D.											
PHYSICIAN'S NAME (Type) James R. Martin MD 5 Shaw Street, Annapolis, Maryland											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 12, 1960		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery				22d. LOCATION (City, town, or county) (State) Annapolis, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home						24a. REC'D BY REGISTRAR SEP 13 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

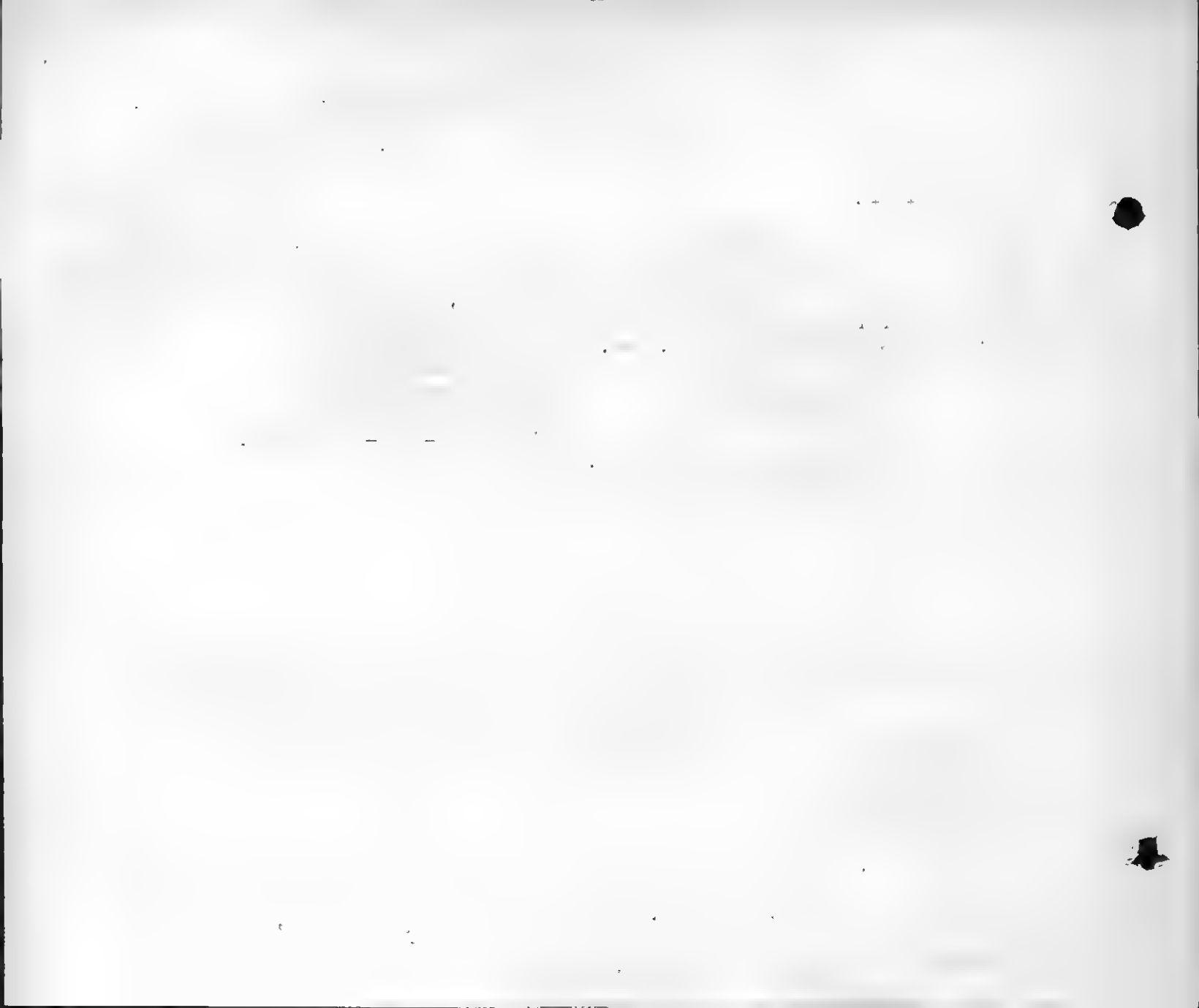
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be received by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



VR A15 (4)
15M 9/59



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

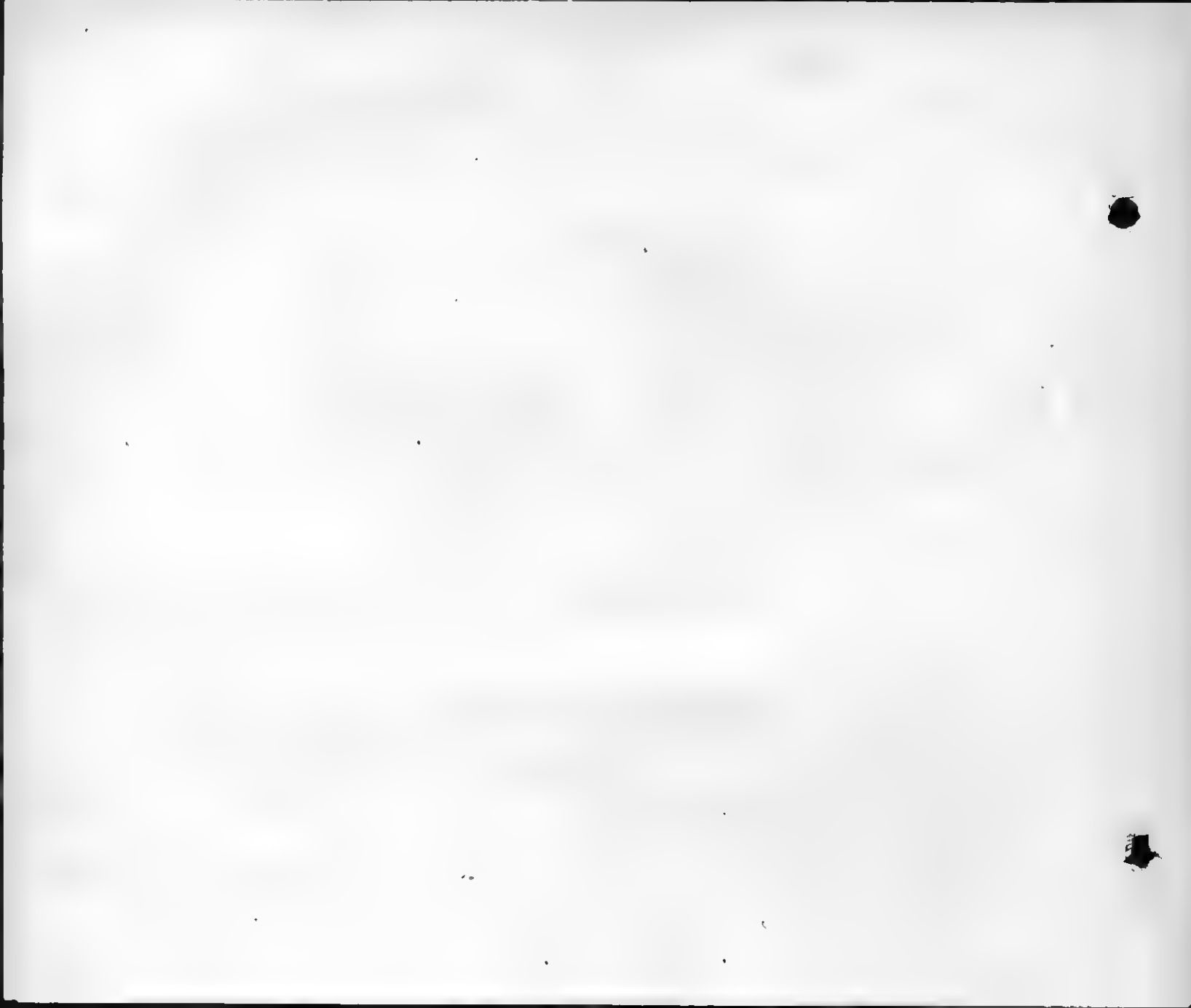
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
9899 CERTIFICATE OF DEATH

09903

1. PLACE OF DEATH o COUNTY <i>Ann Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Ann Arundel</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riviera Beach</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riviera Beach</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>161 Kenwood Road</i>				d. STREET ADDRESS <i>161 Kenwood Road</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Dallas First T. Wells Last</i>				4. DATE OF DEATH Month <i>7</i> Day <i>28</i> Year <i>1960</i>			
5 SEX <i>male</i>		6 COLOR OR RACE <i>white</i>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 28, 1910</i>	
9. AGE (In years last birthday) <i>50</i> yrs.		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>		IF UNDER 24 HRS Hours <i>0</i> Min. <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>pressman</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Sun paper</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>Albert Wells</i>				14. MOTHER'S MAIDEN NAME <i>Annie Bostic</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <i>none</i>		17. INFORMANT <i>Mrs Marie A. Wells</i> Address <i>161 Kenwood Rd., Riviera</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CORONARY THROMBOSIS</i> 42-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>CORONARY SCLEROSIS</i> DUE TO (c) <i>2 1/2 1/2</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>1 1/2 1/2</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. <i>19</i> Day. <i>19</i> Year. <i>19</i> Hour o. m. <i>19</i> p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>8/11</i> 19 <i>60</i> , to <i>8/12</i> 19 <i>60</i> , that (I) (we) last saw the deceased alive on <i>7/5</i> 19 <i>60</i> and that death occurred of <i>8/12</i> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>J. Brady Smith</i> M.D.				22b. DATE SIGNED <i>9/9/60</i>			
22c. PHYSICIAN'S NAME (Type) <i>J. Brady Smith</i>				22d. ADDRESS <i>Riviera Beach, Md. 21154</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Sept 12, 1960</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John A. Moran</i> ADDRESS <i>3000 E. Baltimore St., Balto</i>				25a. REC'D BY REGISTRAR <i>SEP 13 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Charles S. House</i>	

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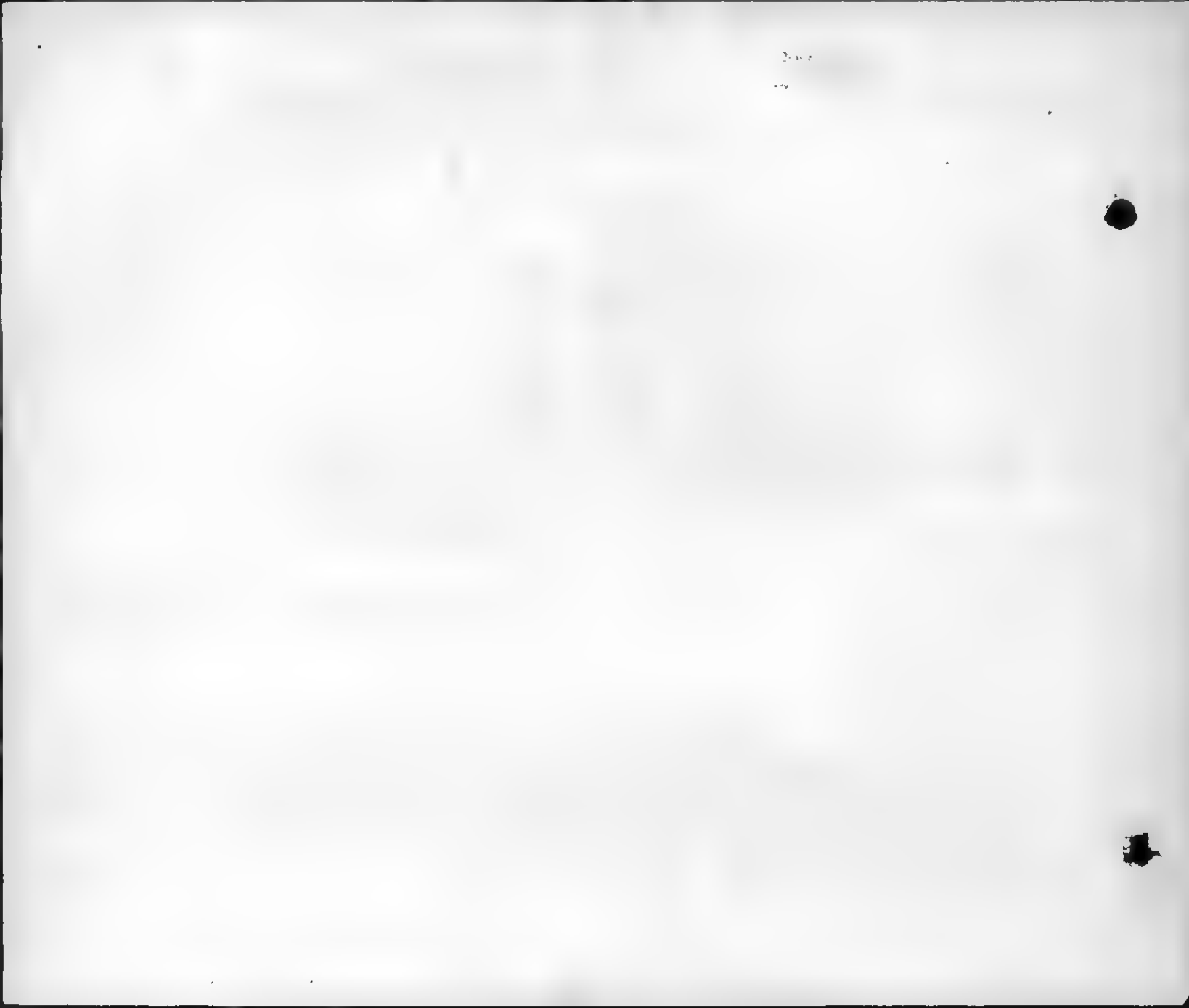
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LINTHICUM HEIGHTS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Linticum</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>167 S. Camp Meade Rd</u>		d. STREET ADDRESS <u>167 S. Camp Meade Rd</u>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM</u> First Middle Last <u>WENGERT</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>17</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>20 Aug 1897</u>
9. AGE (In years last birthday) <u>63</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steamfitter (Ret)</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Self. Emp.</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md</u>	
13. FATHER'S NAME <u>Conrad Wengert</u>		14. MOTHER'S MAIDEN NAME <u>Barbara (unhus.)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs. Emma Wengert</u>		Address <u>Same as I-2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>170.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1957</u> to <u>Sept 17, 1960</u> , that I last saw the deceased alive on <u>Sept 16, 1960</u> , and that death occurred at <u>7:20 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. Milton Linticum</u> M.D.		ADDRESS (Street, city or town, state) <u>203 E. York Rd Linticum Heights, Md</u> DATE SIGNED <u>Sept 18, 1960</u>	
PRINTED NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>20 Sept 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>John H. Green Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Blon Bowie Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard V. Bright</u>		24. REC'D BY REGISTRAR DATE <u>SEP 22 '60</u>	
ADDRESS <u>Blon Bowie, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kneass</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9936

CERTIFICATE OF DEATH

Reg. Dist. No.

09905

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 7 years 10 mo. 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Crownsville State Hospital				d. STREET ADDRESS Hill Street			
3. NAME OF DECEASED (Type or print) First John Middle Walter Last Winston				4. DATE OF DEATH Month 9 Day 19 Year 19 60			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 27, 1873	
9. AGE (In years last birthday) 86 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Newton Winston			
14. MOTHER'S MAIDEN NAME Betty ?				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. Unknown				17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Cancer, Primary DUE TO (c) -----							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) -----				20g. (County) -----		20h. (State) -----	
21. I certify that I attended the deceased from 11/11 , 19 52 to 9/19 , 19 60 , that I last saw the deceased alive on 9/19 , 19 60 and that death occurred at 6:25 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 9/20/60							
ACTUAL SIGNATURE Lionel McHenry Mapp M.D.				PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9/23/60		22c. NAME OF CEMETERY OR CREMATORY Crownsville State Hospital	
22d. LOCATION (City, town, or county) Crownsville				22e. (State) Maryland		22f. REC'D BY REGISTRAR DATE SEP 28 '60	
22g. REGISTRAR'S SIGNATURE Arthur S. Howard				22h. REGISTRAR'S SIGNATURE Arthur S. Howard			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9896

CERTIFICATE OF DEATH

Reg. Dist. No. 09906

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION A.A. Gen'l. Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LILLIAN H. Last (Scheidegger) WOCKENFUSS				4. DATE OF DEATH Month 25th September Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8th July 1891	
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME J.C. Heil				14. MOTHER'S MAIDEN NAME (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. unknown		17. INFORMANT Mr. Albert E. Wockenfuss Same As #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio-vascular Disease 443X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 8 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct , 19 46 to Sept 25 , 19 60 , that I last saw the deceased alive on Sept 23 , 19 60 , and that death occurred at 3 P M, from the causes and on the date stated above. ACTUAL SIGNATURE Edward G. Skerritt M.D. Glen Burnie, Md. DATE SIGNED Sept 27, 1960 PHYSICIAN'S NAME (Type) Edward G. Skerritt Glen Burnie, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 28th Sept. 1960		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		22d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Richard V. Singleton				24a. REC'D BY REGISTRAR DATE SEP 29 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Farris	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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Form with multiple lines for text entry, including fields for name, date, and location. The form is oriented horizontally but the text is mirrored from the reverse side of the page.